North Carolina Child Fatality Task Force Annual Report to the Governor and General Assembly

RALEIGH, NC // JANUARY 2019

Our **Children** *Our* **Future**
Our **RESPONSIBILITY**

JANUARY 2019

The Honorable Roy Cooper
Governor, State of North Carolina

Distinguished Members of the North Carolina General Assembly

Child Fatality Task Force

We are pleased to submit to you this annual report of the North Carolina Child Fatality Task Force. This year's report brings the good news of seeing a slight decrease in the child death rate for 2017 as compared to recent years, along with the reality that far too many children in our state die of preventable causes.

Preventing child deaths is possible, and since 1991, the Task Force has been part of a broader Child Fatality Prevention System that has contributed to a 47 percent decrease in child deaths in North Carolina. The Task Force has for 27 years studied the causes of child deaths and child maltreatment along with the strategies to prevent them. Some prevention strategies are neither complicated nor costly and others are complex and require more resources to implement. Regardless, the Task Force and the broader system has taken on the challenges of advancing prevention strategies and policies, as any complexities and costs of doing so pale in comparison to the devastating personal, societal, and economic impacts of losing a child.

This report includes a variety of recommendations addressing a range of issues such as suicide prevention, firearm safety, safe infant sleep, motor vehicle safety, support for Raise the Age implementation, and the harmful impacts of nicotine use. The report also includes a set of recommendations aimed at strengthening our own statewide Child Fatality Prevention System, a result of efforts during the past year to bring system stakeholders together with state and national experts to take a closer look at the system and identify its strengths and challenges.

On page 50 of this report, we invite you to read about policies that the Task Force had a role in advancing during the 2018 legislative session, including a study to strengthen maternal and infant health care, the addition of three conditions to the state's newborn screening program, funding for programs and school professionals aimed at addressing the mental health needs of students in schools and at preventing youth suicide, and funding for tobacco use prevention. You will also find included here reports addressing the work of the state and local Child Fatality Prevention Teams.

Task Force success in advancing public policy to save children's lives depends on state leaders who recognize that prioritizing our state's resources to ensure the wellbeing of our children is to ensure the wellbeing of North Carolina's future. Thankfully, the Task Force's long track record in advancing policy demonstrates that we have indeed had many such responsive leaders in our state, and we hope that the recommendations in this report will be seen once again as an opportunity to invest in North Carolina's future.

Karen McLeod
CHAIR

Kella Hatcher
EXECUTIVE DIRECTOR

Table of Contents

NC Child Fatality Task Force Study Process

The Child Fatality Task Force (CFTF or "Task Force") taps a broad range of expertise and resources to formulate its recommendations. Three committees meet to study data, hear from experts, and prepare recommendations for consideration by the full Task Force.

During its most recent study cycle, the Task Force had a total of 10 meetings, including seven committee meetings and three full Task Force meetings where attendees heard some 45 presentations. Experts and leaders presenting to the Task Force and its committees represented state and local agencies, academic institutions, as well as state and community programs such as:

- Birth Defects Monitoring Program, State Center for Health Statistics, NC Division of Public Health
- Carolina Swims Foundation
- Child Welfare Policy and Programs, NC Division of Social Services
- Child Welfare Services, NC Division of Social Services
- Children's Advocacy Centers of North Carolina
- Council for the Model Aquatic Health Code, Centers for Disease Control and Prevention
- Division of Child Development and Early Education, NC Department of Health and Human Services
- Essentials for Childhood, Women's and Children's Health Section, NC Division of Public Health
- Injury and Violence Prevention Branch, Division of Public Health
- Institute for Transportation Research and Education, NC State University
- Juvenile Justice, NC Department of Public Safety
- Maternal Mortality Review Program, Women's Health Branch, NC Division of Public Health
- NC Child
- NC Child Fatality Task Force
- NC Tobacco Prevention and Control Branch, NC Division of Public Health
- Office of the Secretary, NC Department of Health and Human Services
- Perinatal Health Strategic Plan, Women's Health Branch, NC Division of Public Health
- Prevent Child Abuse North Carolina
- Public Swimming Pool Program, NC Division of Public Health
- State Child Fatality Prevention Team, Office of the Chief Medical Examiner
- The National Center for Fatality Review and Prevention
- The Redwoods Group
- Town of Brevard Police Department
- University of North Carolina Center for Maternal and Infant Health
- University of North Carolina School of Medicine, Obstetrics and Gynecology
- Women's and Children's Health Section, NC Division of Public Health

The **Intentional Death Prevention Committee** studies homicide, suicide, and child maltreatment. For the fourth year in a row, several recommendations from this committee address suicide prevention, some of which first appeared on the 2017 Action Agenda but have not yet fully advanced. These recommendations were informed by agency representatives and suicide prevention experts who identified youth suicide priorities from the statewide 2015 Suicide Prevention Plan. Recommendations include mandatory suicide prevention training and protocols in schools, increasing the number of school nurses in high need communities, and creating and funding a state-level coordinator position for school social workers. Another 2019 legislative recommendation from the Intentional Death Prevention Committee addresses strengthening North Carolina's Infant Safe Surrender law, which was originally advanced by the Task Force in 2001. This recommendation was informed by experts in juvenile law as well as research on other states' safe surrender laws.

Administrative (non-legislative) efforts by this committee for the 2019 Agenda will include further study to address three separate issues: child abuse and neglect reporting, child sex abuse prevention education in childcare settings, and opportunities for having a three-year lead suicide prevention coordinator position in North Carolina to coordinate cross-sector prevention efforts.

The **Perinatal Health Committee** studies infant mortality and women's health. A focus for the 2019 agenda is to increase state support to prevent sleep-related infant deaths, as data from the Office of the Chief Medical Examiner presented to the Task Force show a high number of infant deaths occurring in unsafe sleep environments each year. Recognizing that tobacco use during pregnancy is directly associated with the top causes of infant mortality in North Carolina, the committee also recommends endorsing efforts to obtain increased state funding for Quitline NC, which provides tobacco cessation services statewide and has a special protocol for pregnant women. The Committee continues to work with a large cohort of partners to advance the NC Perinatal Health Strategic Plan.

The scope of issues addressed in child fatality team reviews and throughout the child fatality prevention system touches each of the three Task Force committees. In 2018, potential changes related to strengthening the statewide Child Fatality Prevention System were examined and approved by the Perinatal Health Committee before being sent to the full Child Fatality Task Force for consideration. Two-thirds of all child deaths in North Carolina are to infants, and the committee discussed the importance of ensuring effective reviews of infant deaths, hearing from a national expert about specialized Fetal and Infant Mortality Reviews.

This committee also has an administrative item for 2019 to learn more from a study taking place related to workplace accommodations for pregnancy and lactation.

The **Unintentional Death Prevention Committee** studies unintentional injury and death. This committee determined that it wanted to repeat its recommendation to advance funding for a statewide firearm safe storage initiative as one strategy to address the many firearm-related suicides, homicides, and unintentional deaths to kids that occur each year. This recommendation was informed by the work of a diverse group of firearm safety stakeholders, a group that came together in 2017 at the recommendation of the State Child Fatality Prevention Team, who brought the issue of youth access to lethal means to the attention of the Task Force.

Motor vehicle safety was addressed by this committee through its repeat recommendation to make rear seat restraints a "primary" traffic offense for all to increase use of seat belts in the back seat and prevent deaths and injuries. The committee also

repeated its recommendation for legislation that would strengthen impaired driving laws by requiring ignition interlocks for all DWI offenders, a strategy recommended by the CDC as being highly effective in preventing repeat DWI offenses.

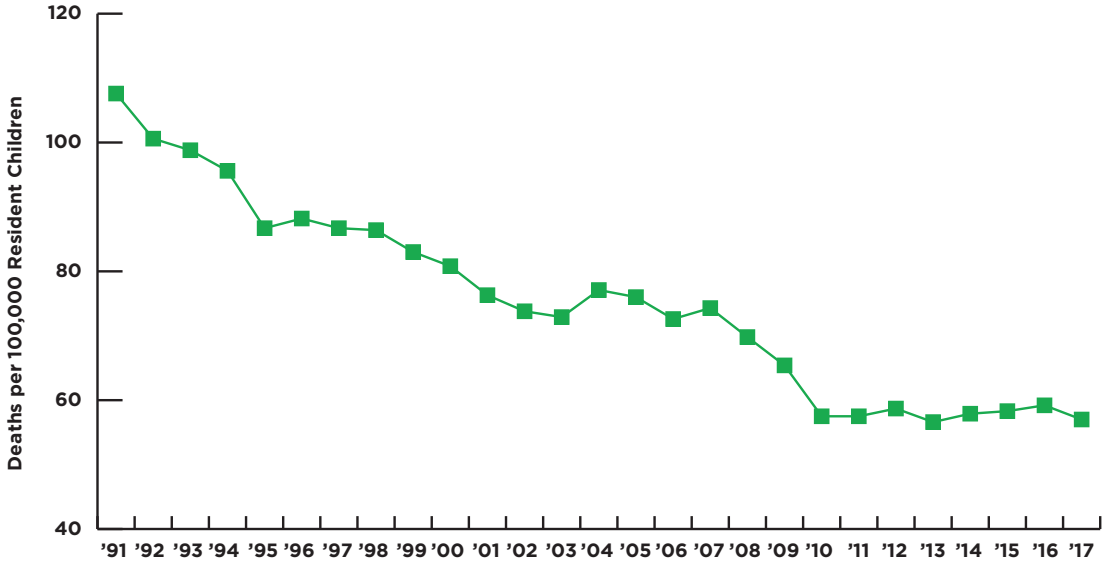
Recognizing the recent and dramatic increase in the use of harmful e-cigarettes by youth, this committee also recommended endorsing efforts to increase state funding for youth nicotine use prevention.

With respect to non-legislative items, the committee recommended administrative support to further study issues related to water safety with a focus on requirements related to lifeguards at public pools.

The Child Fatality Task Force Executive Committee thanks all Task Force Members, contributing experts, and community volunteers who devoted their time and expertise to Task Force work. Their efforts and commitment to protecting the children of North Carolina are reflected in the 2019 Action Agenda.

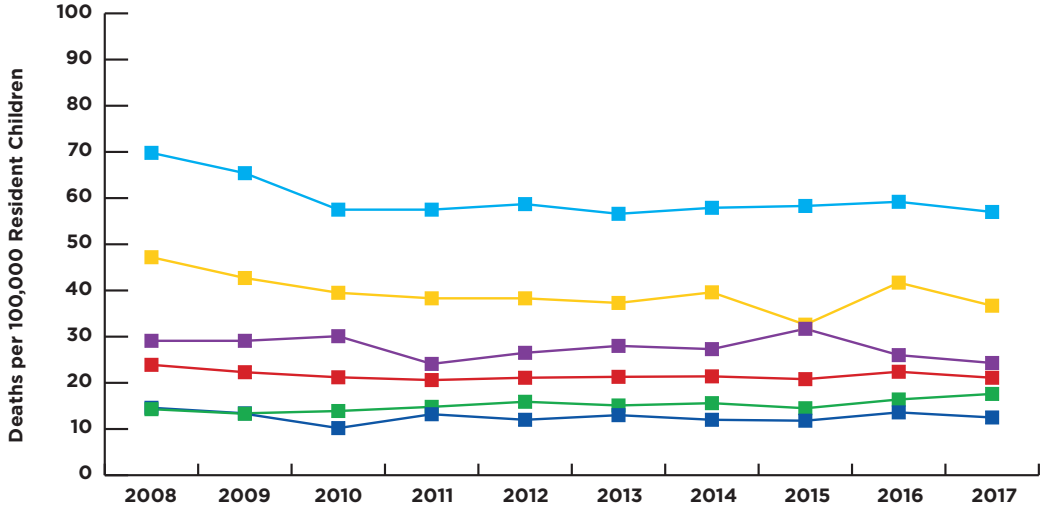
*The rate of child deaths in North Carolina **has decreased by 47%** since the 1991 creation of the Child Fatality Task Force and the broader Child Fatality Prevention System.*

1991-2017 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES, AGES BIRTH THROUGH 17 YEARS



1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
107.6	100.6	98.8	95.6	86.7	88.2	86.7	86.4	83.0	80.8	76.3	73.8	72.9	77.1	76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.6	57.9	58.3	59.2	57.0

2008-2017 TRENDS IN NORTH CAROLINA CHILD DEATH RATES† BY AGE GROUP



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
TOTAL Ages 0-17	69.8	65.4	57.5	57.5	58.7	56.6	57.9	58.3	59.2	57.0
Ages 1-4	29.1	29.1	30.1	24.1	26.5	28.0	27.3	31.7	26.0	24.3
Ages 5-9	14.3	13.3	10.2	13.2	12.0	13.0	12.0	11.8	13.6	12.5
Ages 10-14	14.6	13.4	13.9	14.8	15.9	15.1	15.6	14.5	16.4	17.6
Ages 15-17	47.2	42.7	39.5	38.3	38.3	37.3	39.6	32.6	41.7	36.7
(Excl, Infants) Ages 1-17	23.9	22.3	21.2	20.6	21.1	21.3	21.4	20.8	22.4	21.1

† Child death rates prior to 2017 have been recalculated using the latest available population data

Note on Cause of Death Figures: Numbers in this report from the State Center for Health Statistics (SCHS) may differ slightly from numbers reported later by the office of the Chief Medical Examiner (OCME). The State Center for Health Statistics bases its statistics on death certificate coding only, and closes out annual data at a specific point in time. The OCME makes its determinations utilizing a variety of information sources when conducting its death reviews, does not close out its data, and some of its cases are still pending when the State Center for Health Statistics closes its annual data files. Therefore, the cause and manner determined by the OCME may be modified based on OCME review after the time period during which the SCHS finalizes annual data files.

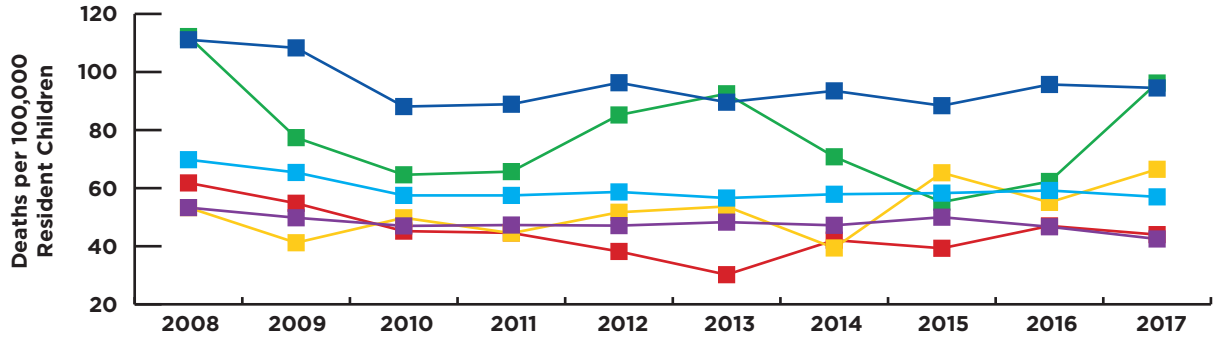
2017 NC RESIDENT CHILD DEATHS BY AGE GROUP & CAUSE OF DEATH

	TOTAL AGES 0-17		AGE GROUP (years)									
			Infants		1-4		5-9		10-14		15-17	
Cause of Death:	N	%	N	%	N	%	N	%	N	%	N	%
• Perinatal Conditions	460	35.0	458	34.9	1	0.1	0	0.0	1	0.1	0	0.0
• Illnesses	253	19.3	90	6.9	39	3	45	3.4	44	3.4	35	2.7
• Birth Defects	172	13.1	145	11	11	0.8	6	0.5	8	0.6	2	0.2
• Motor Vehicle Injuries	100	7.6	5	0.4	17	1.3	11	0.8	26	2	41	3.1
• Other Unintentional Injuries	75	5.7	15	1.1	26	2	9	0.7	4	0.3	21	1.6
– Suffocation/Choking/Strangulation	21	1.6	13	1	7	0.5	0	0	1	0.1	0	0
– Drowning	25	1.9	1	0.1	9	0.7	5	0.4	2	0.2	8	0.6
– Poisoning	12	0.9	1	0.1	3	0.2	0	0	1	0.1	7	0.5
– Bicycle	1	0.1	0	0	0	0	0	0	0	0	1	0.1
– All Other Accidental Injuries	16	1.2	0	0	7	0.5	4	0.3	0	0	5	0.4
• Homicide	55	4.2	15	1.1	9	0.7	6	0.5	6	0.5	19	1.4
– Involving Firearm	26	2	0	0	1	0.1	3	0.2	4	0.3	18	1.4
– All Other Homicides	29	2.2	15	1.1	8	0.6	3	0.2	2	0.2	1	0.1
• Suicide	44	3.4	0	0	0	0	0	0	20	1.5	24	1.8
– by Firearm	18	1.4	0	0	0	0	0	0	10	0.8	8	0.6
– by Hanging	24	1.8	0	0	0	0	0	0	10	0.8	14	1.1
– by Poisoning	1	0.1	0	0	0	0	0	0	0	0	1	0.1
– All Other Suicides	1	0.1	0	0	0	0	0	0	0	0	1	0.1
• All Other Causes of Death	154	11.7	124	9.4	16	1.2	2	0.2	7	0.5	5	0.4
TOTAL DEATHS	1313	100	852	64.9	119	9.1	79	6	116	8.8	147	11

† Child death rates prior to 2017 have been recalculated using the latest available population data

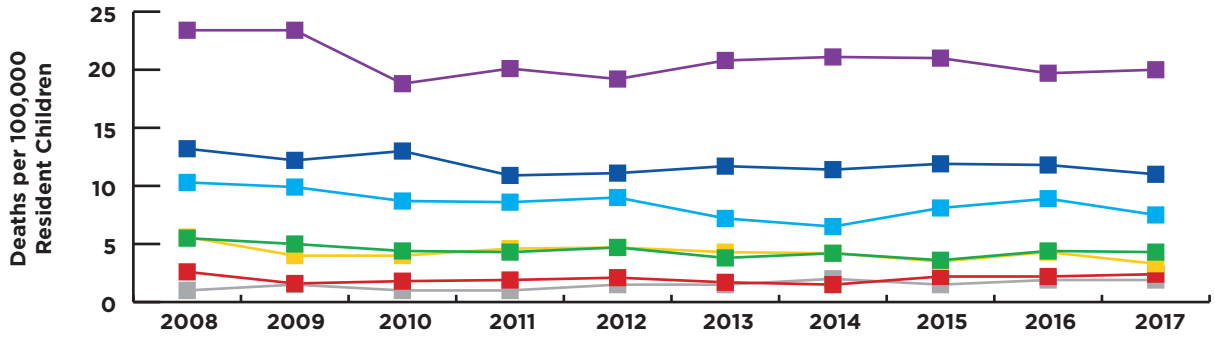
Note on Cause of Death Figures: Numbers in this report from the State Center for Health Statistics (SCHS) may differ slightly from numbers reported later by the office of the Chief Medical Examiner (OCME). The State Center for Health Statistics bases its statistics on death certificate coding only, and closes out annual data at a specific point in time. The OCME makes its determinations utilizing a variety of information sources when conducting its death reviews, does not close out its data, and some of its cases are still pending when the State Center for Health Statistics closes its annual data files. Therefore, the cause and manner determined by the OCME may be modified based on OCME review after the time period during which the SCHS finalizes annual data files.

2008-2017 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES BY RACE/ETHNICITY, AGES BIRTH THROUGH 17 YEARS



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
TOTAL	69.8	65.4	57.5	57.5	58.7	56.6	57.9	58.3	59.2	57.0
Non-Hispanic White	53.3	49.8	47.0	47.3	47.1	48.3	47.2	50.0	46.7	42.5
Non-Hispanic Black	111.1	108.3	88.1	88.9	96.3	89.6	93.5	88.4	95.7	94.5
Non-Hispanic American Indian	112.2	77.4	64.6	65.7	85.2	92.5	70.8	55.2	62.3	96.2
Non-Hispanic Other	53.3	41.2	49.8	44.5	51.7	53.7	39.4	65.3	55.1	66.5
Hispanic/Latino	61.8	54.8	45.2	44.6	38.2	30.2	42.1	39.3	47.0	44.0

2008–2017 TRENDS IN NORTH CAROLINA RESIDENT CHILD DEATH RATES FOR SELECTED CAUSE OF DEATH, AGES BIRTH THROUGH 17 YEARS



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Birth Defects	10.3	9.9	8.7	8.6	9.0	7.2	6.5	8.1	8.9	7.5
Perinatal Conditions	23.4	23.4	18.8	20.1	19.2	20.8	21.1	21.0	19.7	20.0
Illnesses	13.2	12.2	13.0	10.9	11.1	11.7	11.4	11.9	11.8	11.0
Motor Vehicle	5.5	5.0	4.4	4.3	4.7	3.8	4.2	3.6	4.4	4.3
Other Accidents	5.6	4.0	4.0	4.6	4.7	4.3	4.2	3.5	4.3	3.3
Homicide	2.6	1.6	1.8	1.9	2.1	1.7	1.5	2.2	2.2	2.4
Suicide	1.0	1.5	1.0	1.0	1.5	1.5	2.0	1.5	1.9	1.9

LEADING CAUSES OF CHILD DEATH BY AGE GROUP, NC RESIDENTS 2017

ALL AGES, 0-17			
Rank	Cause	Number	%
1	Conditions originating in the perinatal period	460	35.0
2	Congenital anomalies (birth defects)	172	13.1
3	Motor vehicle injuries	100	7.6
4	Other Unintentional injuries	73	5.6
5	Homicide	55	4.2
6	Cancer	46	3.5
7	Suicide	44	3.4
8	Diseases of the heart	32	2.4
9	Pneumonia & influenza	14	1.1
10	Cerebrovascular disease	12	0.9
All other causes (Residual)		305	23.2
TOTAL DEATHS — ALL CAUSES		1,313	100.0

AGES 1 TO 17			
Rank	Cause	Number	%
1	Motor vehicle injuries	95	20.6
2	Other Unintentional injuries	59	12.8
3	Cancer	45	9.8
4	Suicide	44	9.5
5	Homicide	40	8.7
6	Congenital anomalies (birth defects)	27	5.9
7	Diseases of the heart	22	4.8
8	Chronic lower respiratory diseases	10	2.2
9	Cerebrovascular disease	8	1.7
9	Pneumonia & influenza	8	1.7
All other causes (Residual)		103	22.3
TOTAL DEATHS — ALL CAUSES		461	100.0

LEADING CAUSES OF CHILD DEATH BY AGE GROUP, NC RESIDENTS 2017

INFANTS			
Rank	Cause	Number	%
1	Short gestation - low birthweight	162	19.0
2	Congenital anomalies (birth defects)	145	17.0
3	Maternal complications of pregnancy	59	6.9
4	Complications of placenta, cord, and membranes	35	4.1
5	Bacterial sepsis	30	3.5
6	Respiratory distress	25	2.9
7	Diseases of the circulatory system	17	2.0
8	Atelectasis	16	1.9
9	Homicide	15	1.8
10	Cerebrovascular disease	14	1.6
All other causes (Residual)		334	39.2
TOTAL DEATHS — ALL CAUSES		852	100.0

AGES 5 TO 9			
Rank	Cause	Number	%
1	Cancer	14	17.7
2	Motor vehicle injuries	11	13.9
3	Other Unintentional injuries	9	11.4
4	Diseases of the heart	8	10.1
5	Congenital anomalies (birth defects)	6	7.6
5	Homicide	6	7.6
7	Chronic lower respiratory diseases	5	6.3
8	Pneumonia & influenza	4	5.1
9	In-situ/benign neoplasms	2	2.5
All other causes (Residual)		14	17.7
TOTAL DEATHS — ALL CAUSES		79	100.0

AGES 15 TO 17			
Rank	Cause	Number	%
1	Motor vehicle injuries	41	27.9
2	Suicide	24	16.3
3	Other Unintentional injuries	21	14.3
4	Homicide	19	12.9
5	Cancer	12	8.2
6	Diseases of the heart	5	3.4
7	Congenital anomalies (birth defects)	2	1.4
8	Anemias	1	0.7
8	Cerebrovascular disease	1	0.7
8	Chronic lower respiratory diseases	1	0.7
8	Nephritis, nephrotic syndrome, & nephrosis	1	0.7
8	Complications of medical and surgical care	1	0.7
All other causes (Residual)		18	12.2
TOTAL DEATHS — ALL CAUSES		147	100.0

AGES 1 TO 17			
Rank	Cause	Number	%
1	Other Unintentional injuries	25	21.0
2	Motor vehicle injuries	17	14.3
3	Congenital anomalies (birth defects)	11	9.2
4	Homicide	9	7.6
5	Cancer	7	5.9
6	Diseases of the heart	4	3.4
6	Cerebrovascular disease	4	3.4
8	Pneumonia & influenza	2	1.7
9	In-situ/benign neoplasms	1	0.8
9	Acute bronchitis & bronchiolitis	1	0.8
9	Nephritis, nephrotic syndrome, & nephrosis	1	0.8
9	Conditions originating in the perinatal period	1	0.8
All other causes (Residual)		36	30.3
TOTAL DEATHS — ALL CAUSES		119	100.0

AGES 10 TO 14			
Rank	Cause	Number	%
1	Motor vehicle injuries	26	22.4
2	Suicide	20	17.2
3	Cancer	12	10.3
4	Congenital anomalies (birth defects)	8	6.9
5	Homicide	6	5.2
6	Diseases of the heart	5	4.3
7	Chronic lower respiratory diseases	4	3.4
7	Other Unintentional injuries	4	3.4
9	Cerebrovascular disease	3	2.6
10	Septicemia	2	1.7
10	Pneumonia & influenza	2	1.7
All other causes (Residual)		24	20.7
TOTAL DEATHS — ALL CAUSES		116	100.0

NC Child Fatality Task Force 2019 Action Agenda

Legislative "support" items receive the highest level of support from the CFTF.
Legislative "endorse" items are led by others and endorsed by the CFTF.
"**Administrative" items** are non-legislative items sought to be further examined by the CFTF.
(Note: Items with an asterisk (*) are those carrying over from the 2018 CFTF Action Agenda.)

LEGISLATIVE SUPPORT & ENDORSE

A. Recommendations to prevent infant deaths

1. **Support** a state appropriation of $85,000 in additional funding to expand the Safe Sleep NC program that works to prevent sleep-related infant deaths.
2. ***Support** legislative changes to strengthen North Carolina's Infant Safe Surrender law to make it more likely the law will be used in circumstances for which it was intended to protect a newborn infant at risk of abandonment or harm by making legislative changes to accomplish the following: 1) remove "any adult" from those designated to accept a surrendered infant; 2) provide information to a surrendering parent; 3) strengthen protection of a surrendering parent's identity; 4) incorporate steps to help ensure the law is only applied when criteria are met.

B. Recommendations to prevent youth suicide and firearm-related deaths and injuries to children

1. ***Support** legislation requiring suicide prevention training and a risk referral protocol in schools, with specific requirements related to frequency and duration of the training, who receives the training, and minimum criteria for training components.
2. ***Support** for an increase in funding to the School Nurse Funding Initiative by $5 million recurring to add 100 school nurses in high-need communities to move toward meeting nationally recommended ratios.
3. ***Endorse** an appropriation of $100,000 in recurring funds for a full-time School Social Worker Consultant to be housed in the Department of Public Instruction Student Support Services to provide coordination, training, support, and data collection for school social workers in North Carolina.
4. ***Support** state funding for a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe

storage and distribution of free gun locks; funding to go to DHHS to appropriately engage a third-party organization to implement the initiative. (Two-year funding estimate is for $155,700: $86,500 for year one; $69,200 for year two.)

C. Recommendations to prevent motor vehicle-related injuries and deaths to children

1. ***Support** legislation allowing for primary enforcement of all unrestrained back seat passengers and increase fine for unrestrained back seat passengers from $10 to $25.
2. ***Support** legislation that would require ignition interlocks for all DWI offenders.

D. Recommendation for system supports to meet the needs of youth in the Juvenile Justice System

Support $50 million in recurring state funding for the effective implementation of Raise the Age legislation.

E. Recommendations to prevent harm to infants and youth caused by tobacco and nicotine use

1. ***Endorse** additional Quitline NC funding of $3 million.
2. ***Endorse** at least $7 million in funding for youth nicotine use prevention, including e-cigarettes.

F. Recommendations to strengthen the statewide Child Fatality Prevention System

1. **Support** legislation, agency action, and policy change to implement the following changes to the Child Fatality Prevention System (CFP System):
   a. Implement centralized state-level staff with whole-system oversight in one location within the Department of Health and Human Services (DHHS) with the formation of a new cross-sector Fatality Review and Data Group and with child fatality staff in the Office of the Chief Medical Examiner (OCME) remaining in OCME.
   b. Implement a centralized electronic data and information system that includes North Carolina joining the National Child Death Review Case Reporting System.
   c. Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities.
   d. Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one with different procedures and required participants for different types of reviews (including intensive-type reviews of abuse or neglect-related deaths with state-level staff assistance) and giving teams the option to choose whether to be single or multi-county teams. DHHS should study and determine an effective framework for meeting the federal requirements for Citizen Review Panels and for reviewing active DSS cases without using all local review teams for these purposes.

e. Formalize the three committees of the Child Fatality Task Force (CFTF) with certain required committee members and expand the required CFTF report to address the whole CFP system with required report to be distributed to additional state leaders beyond the Governor and General Assembly.

2. **Support** for maintaining current state funding for existing positions and operations that support Child Fatality Prevention System work, and for additional recurring funding to support this work pursuant to DHHS determinations to be made related to the most appropriate placement and staffing configuration for this central office as well as funding needs of local health departments to support CFP system work. (Funding estimate is for $550K.)

3. Pursuant to DHHS determinations to be made related to launching a Fetal and Infant Mortality Review Program to inform state-level action related to the prevention of child deaths, **support** funding to enable implementation of the evidence-informed practice of FIMR as a pilot. (Funding estimate is for $300K.)

ADMINISTRATIVE ISSUES

Administrative support for CFTF Executive Committee to explore and pursue possibilities for funding for a three-year lead suicide prevention coordinator position in North Carolina that would coordinate cross-agency efforts to carry out implementation of the 2015 NC Suicide Prevention Strategic Plan and determine a sustainability plan for ongoing statewide coordination for implementation of the Strategic Plan.

Administrative support for CFTF to further study the issue of child abuse and neglect reporting including but not limited to the following issues: benefits, challenges, and resources needed for a statewide reporting hotline; the potential use of other tools such as mobile applications for reporting; incorporation of prevention education in reporting tools; and policies related to how cases reported to DSS but screened out for not involving a parent, guardian, custodian or caretaker are referred to law enforcement.

Administrative support for CFTF to further study the efficacy of requiring additional training related to child sex abuse prevention in child care settings and other K-12 settings.

Administrative support for the work of the North Carolina Breastfeeding Coalition, MomsRising, NC Child, and the Carolina Global Breastfeeding Institute in their efforts to: examine ways in which pregnancy and lactation accommodations in the workplace can decrease infant mortality, increase child health and well-being, and address racial and socioeconomic health disparities; and research policies in place in other states that address these types of workplace accommodations.

Administrative support for the CFTF to work with the YMCA of the Triangle to engage stakeholders and experts to further examine issues and data related to a proposal for North Carolina to adopt provisions of the CDC's Model Aquatic Health Code pertaining to lifeguards at public pools, bringing information back to the CFTF for consideration.

Explanation of CFTF 2019 Legislative Action Agenda Items

A. RECOMMENDATIONS TO PREVENT INFANT DEATHS

1. *Support* a state appropriation of $85,000 in additional funding to expand the Safe Sleep NC program that works to prevent sleep-related infant deaths.

Sleep-related infant death remains a leading cause of infant mortality both in North Carolina and nationally. In North Carolina during 2016, there was a total of 873 infant deaths.[1] According to the North Carolina Office of the Chief Medical Examiner, 130 infant deaths in 2016 were related to an unsafe sleep environment with an additional 10 certified as Sudden Infant Death Syndrome (SIDS).[2]

Looking at a range of years from 2012 to 2016, the Office of the Chief Medical Examiner reported that 544 infant deaths were associated with unsafe sleep environments (for example, an infant found with his or her face covered by a blanket, found sleeping on a couch with the infant's face to the back of the couch or between cushions, sharing a sleep space with another individual).[3] Of those 544 infant deaths associated with unsafe sleep environments, 395 were involved with bed sharing, also referred to as co-sleeping, the intentional or unintentional practice of an infant sharing a sleep space with another individual.[4]

During the past 20 years, the number of parents reporting sharing a bed with their infants has grown from about 6 percent of parents in 1993[5] to 24 percent in 2015.[6] This common practice is of concern because of

[1] North Carolina State Center for Health Statistics, Causes of Infant Mortality, 2016.

[2] Office of the Chief Medical Examiner-Division of Public Health North Carolina Department of Health and Human Services, 2018. Sleep-Related Death Infant Investigations 2012-2016. According to the Office of the Chief Medical Examiner: "27 infant deaths were classified as accidental asphyxiation manner and means of death related to unsafe sleep environments in which circumstances of a risky situation were known or an overlay was documented when the infant was found unresponsive. In addition, 103 infant deaths were classified as an undetermined unknown manner and means of death in which accidental asphyxiation could not be excluded since the infant was placed in an unsafe sleep environment, a known risk factor for an accidental asphyxiation event. Infant deaths classified with an undetermined cause of death by the medical examiner, may fall under the NC DHHS State Center for Health Statistics death certificate code of R96 to R99, which, in 2016, was the leading cause of death of infant death overall during the postneonatal period."

[3] Office of the Chief Medical Examiner-Division of Public Health North Carolina Department of Health and Human Services, 2018. Sleep-Related Death Infant Investigations 2012-2016.

[4] Ibid.

[5] Colson ER, Willinger M, Rybin D, et al, 2013. Trends and Factors Associated With Infant Bed Sharing, 1993-2010. The National Infant Sleep Position Study. JAMA Pediatr. 167(11):1032–1037. doi:10.1001/jamapediatrics.2013.2560.

[6] MMWR Morb Mortal Wkly Rep. 2018 Jan 12; 67(1): 39–46. Published online 2018 Jan 12. doi: [10.15585/mmwr.mm6701e1] PMCID: PMC5769799 PMID: 29324729.

*The NC Office of the Chief Medical Examiner reported that from 2012 to 2016, **544 infant deaths were associated with unsafe sleep environments**; of those 544 infant deaths, **395 were involved with bed sharing**, also referred to as co-sleeping.*

the awareness of the dangers associated with bed sharing, especially among higher risk infants including those born too soon or too small or in households where tobacco and other substances are used.[7]

Research has found that parents need support navigating the challenges of nighttime parenting, and that they would listen to healthcare providers if counseled about the dangers of the practice of bed sharing and given additional support in adhering to the safe infant sleep recommendations.[8] North Carolina healthcare providers have asked for support engaging parents and caregivers in nuanced conversations about sleep and nighttime parenting to help reduce the risk of infant death.[9] Additional funding to the UNC Center for Maternal and Infant Health for the Safe Sleep NC campaign would support the development and dissemination of online training modules for key healthcare providers, including pediatric providers and home visitors, across the state. It will also allow increased dissemination of education and information for new parents.

2. *Support* legislative changes to strengthen North Carolina's Infant Safe Surrender law to make it more likely the law will be used in circumstances for which it was intended to protect a newborn infant at risk of abandonment or harm by making legislative changes to accomplish the following: 1) remove "any adult" from those designated to accept a surrendered infant; 2) provide information to a surrendering parent; 3) strengthen protection of a surrendering parent's identity; 4) incorporate steps to help ensure the law is only applied when criteria are met.

In 2001 North Carolina passed HB 275 (S.L. 2001-291) known by many as the "Infant Safe Surrender" law. This law was recommended and advanced by the NC Child Fatality Task Force. Such laws exist in every state, often called "safe haven" laws, and although they vary they are all designed to provide a safe alternative for a desperate parent of a newborn who may be tempted to engage in actions harmful to the infant. The 2001 Safe Surrender law altered some provisions in the NC Juvenile Code as well as some criminal law provisions to decriminalize abandonment of a newborn infant under certain circumstances and to modify some procedures involving abandoned newborns. In recent years the Child Fatality Task Force, with input from experts in juvenile law, examined the Safe Surrender law and developed these recommended changes to strengthen the law.[10]

The first change is to remove "any adult" from those designated to accept a surrendered infant. Currently, the law requires four categories of professionals to

[7] American Academy of Pediatrics, 2016. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment, 138 (5) (2016), pp. 1-12, 10.1542/peds.2016-2938

[8] Salm Ward and Balfour, 2016. Infant safe sleep interventions, 1990–2015: A review. Journal of Community Health, 41 (1) (2016), pp. 180-196, 10.1007/s10900-015-0060-y; Moon et al., 2016. Safe infant sleep interventions: What is the evidence for successful behavior change? Current Pediatric Reviews, 12 (1) (2016), pp. 67-75, 10.2174/5733 96311666151026110148.

[9] UNC Center for Maternal and Infant Health.

[10] For more information on CFTF work on Infant Safe Surrender that led to these recommendations, see the 2018 CFTF Annual Report.

accept a safely surrendered infant and says also that "any adult" "may" accept a safely surrendered infant. There are several reasons why the recommendation was made to change this aspect of the law: "any adult" cannot be trained about the requirements of the law nor can "any adult" be expected to provide accurate information about the law to a surrendering parent; there are concerns about human trafficking and unlawful custody transfer when "any adult" may claim an infant was surrendered to him or her pursuant to the law; this kind of "any adult" category is not typical in other states.

The second change involves providing information to a surrendering parent. Currently, no information about safe surrender is required to be provided to a parent who surrenders an infant in NC. When information may be provided, there is no means for ensuring accuracy, consistency, or quality of that information. When possible, surrendering parents should be given accurate information regarding consequences, rights, and options related to safe surrender. Especially since many surrenders are occurring in hospitals after delivery, ensuring that a surrendering parent has good information and resources may yield a different choice by the parent that is ultimately better for both parent and child. This can be accomplished by adding a provision to the law that when possible, a surrendering parent be given information regarding safe surrender requirements, consequences, seeking reunification, voluntarily relinquishment of parental rights, a form to collect medical history information, and available services for help with relevant contact information. To ensure consistency and accuracy, the law can also require that DHHS develop written material that addresses the above information to be used across the state by those eligible to accept a surrendered infant (information can be easily downloaded from the web and local contact information can be filled in).

The third change involves strengthening protection of a surrendering parent's identity. Even though a surrendering parent in North Carolina does not have to give his or her identity at the moment of surrender, current NC law requires the Division of Social Services (DSS) to treat the case the same as any other abuse, neglect, or dependency case once they receive custody – this includes making immediate diligent efforts to identify and locate the surrendering parent for participation in all juvenile proceedings regarding the infant. Protections of a surrendering parent's identity are a critical aspect of safe surrender/ safe haven laws in general, as a parent who believes that his or her identity has protections related to safe surrender may be more likely to use the law in circumstances for which it was intended— to protect a newborn infant at risk of abandonment or harm. Many other states have stronger protections for the identity of a surrendering parent compared to North Carolina. Areas of the NC law where statutory changes could be considered to accomplish strengthening these protections (without changing a non-surrendering parent's rights) include: confidentiality provisions addressing information shared about identity; modification of the immediate response by DSS in safe surrender cases; modification of juvenile court process related to the surrendering parent.

The last change would incorporate steps to help ensure law is only applied when criteria are met. More effort should be taken to ensure safe surrender protections are only available when criteria set out in the law are met because the law provides protections for a surrendering parent with respect to immunity and identity. The types of statutory changes that could be considered to accomplish this include: adding a definition of "safely surrendered infant" and "surrendering parent" for clarification; requiring that the infant be reasonably believed to be under seven days old and without signs of abuse or neglect at the time of surrender; requiring that DSS ascertain from a health care provider that the surrendered infant is, to a reasonable medical certainty, under seven days old and without signs of abuse or neglect; adding a provision that emphasizes that safe surrender law provisions are only applicable when criteria are met.

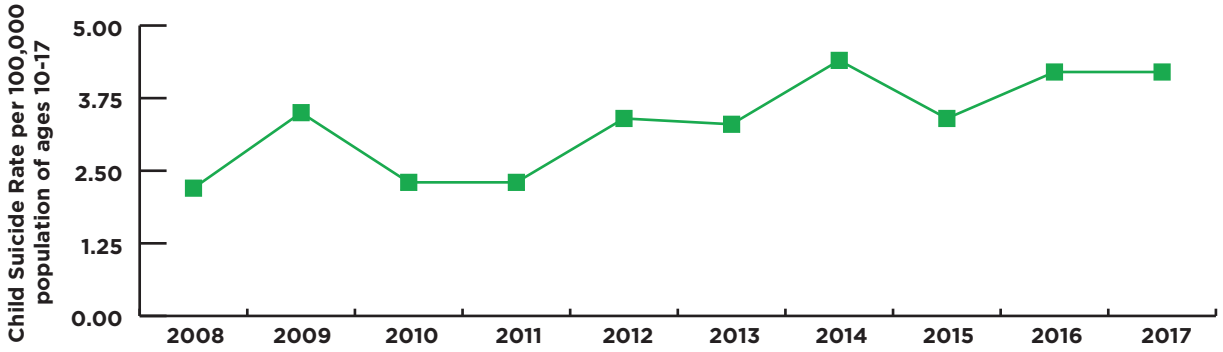
B. RECOMMENDATIONS TO PREVENT YOUTH SUICIDE AND FIREARM-RELATED DEATHS AND INJURIES TO CHILDREN

Youth suicide rates are on the rise in North Carolina and nationally. In North Carolina, suicide is the second leading cause of death for youth between the ages of 10 and 17.[11] Trend data indicate that in North Carolina, suicide rates among 10 to 14 year-olds have increased more than the rate for 15 to 17 year-olds (see charts on next page with rates broken down by age group).[12] In North Carolina, firearms are the lethal means used in almost half of youth suicides and more than half of youth homicides.

For the past several years, the CFTF Action Agenda has featured several recommendations to address youth suicide and access to lethal means, all of which were developed through the study of data and extensive input from experts and stakeholders.[13] Most of these recommendations are being repeated again on this 2019 Action Agenda because they have not yet been fully carried out, and the Task Force continues to believe these are important strategies that North Carolina should implement to prevent child deaths. The following recommendations are also relevant to discussions taking place in North Carolina and nationally regarding the broader topic of school safety and the importance of

These recommendations are also relevant to discussions taking place in North Carolina and nationally regarding the broader topic of ***School Safety*** *and the importance of* ***better addressing the mental health needs*** *of children and teens and ways we can prevent tragedy when students may be at risk of harming themselves or others.*

SUICIDE RATE FOR NC RESIDENT AGES 10-17, FROM 2008-2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Child Suicide Rate	2.2	3.5	2.3	2.3	3.4	3.3	4.4	3.4	4.2	4.2

Source: State Center for Health Statistics, NC Division of Public Health.

[11] Child Deaths in North Carolina, Annual Report for 2017, produced by the N.C. Division of Public Health – Women's and Children's Health Section in conjunction with the State Center for Health Statistics.

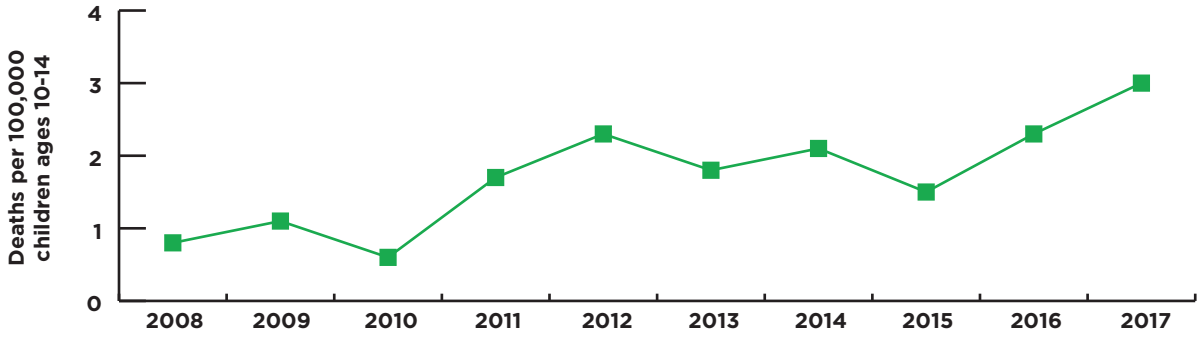
[12] Note that the charts here illustrating suicide rates are according to population numbers of a specific age group, which impacts the rates.

[13] Explanations of the previous work done on these issues, including input from experts and stakeholders, is available in the 2017 and 2018 CFTF Annual Reports.

better addressing the mental health needs of children and teens and ways we can prevent tragedy when students may be at risk of harming themselves or others.

Three of the following strategies involve school personnel because after family and friends, adults in the school setting may be in the best position to recognize a child at risk and be able to react and refer them appropriately. In the case of a school social worker or school nurse, they may also be able to help ensure that the mental health needs of children are addressed before they reach a crisis stage. The fourth recommendation involves safe storage of firearms because firearms are the lethal means in almost half of youth suicides, access to a firearm is a known risk factor for suicide, yet only half of gun owners in North Carolina report safely storing their guns.

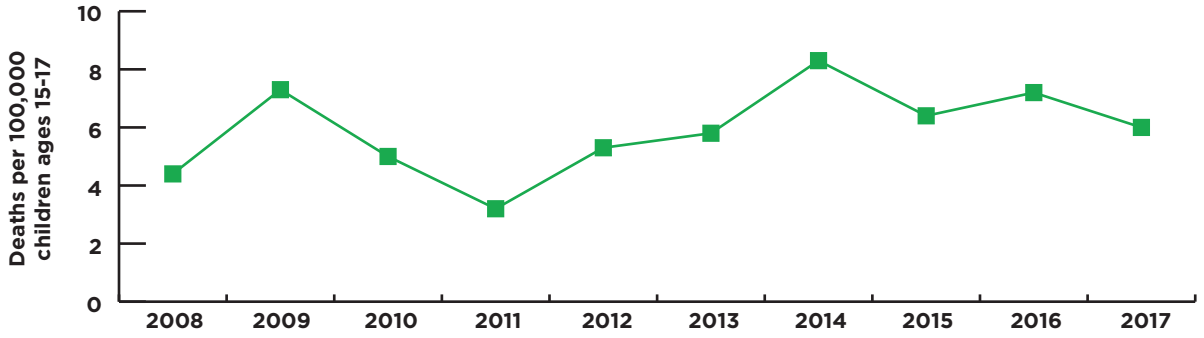
SUICIDE RATE PER 100,000 CHILDREN AGES 10-14, FROM 2008-2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Child Suicide Rate	0.8	1.1	0.6	1.7	2.3	1.8	2.1	1.5	2.3	3.0

Source: 10/29/18 Presentation to NC Child Fatality Task Force by Dr. Stephanie Watkins, epidemiologist for the Women's and Children's Health Section of the NC Division of Public Health, based on data from the State Center for Health Statistics, NC Division of Public Health.

SUICIDE RATE PER 100,000 CHILDREN AGES 15-17, FROM 2008-2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Child Suicide Rate	4.4	7.3	5.0	3.2	5.3	5.8	8.3	6.4	7.2	6.0

Source: Presentation to NC Child Fatality Task Force by Dr. Stephanie Watkins, epidemiologist for the Women's and Children's Health Section of the NC Division of Public Health, based on data from the State Center for Health Statistics, NC Division of Public Health.

1. *Support* legislation requiring suicide prevention training and a risk referral protocol in schools, with specific requirements related to frequency and duration of the training, who receives the training, and minimum criteria for training components.

This recommendation reflects one of the most promising prevention strategies identified through evaluation of the Garrett Lee Smith Youth Suicide Prevention Grants — to increase awareness of risks and seek help when identified.[14] Adults in the school setting may be the first to recognize an issue with a student, but they must be trained to recognize risks and know how and where to refer at-risk kids.

Currently, the existence, attributes, and implementation of suicide prevention programs, efforts, and protocols in North Carolina schools varies widely, and is solely in the discretion of local districts and school administrators. Although legislation passed in 2018 requires the development of a mental health training by the Department of Public Instruction that includes suicide prevention among the topics to be addressed, and requires development of a suicide risk referral protocol, that legislation does not require school personnel to complete suicide prevention training.[15] Many states have already passed some type of legislation requiring suicide prevention training in schools.

Subject matter experts who informed this recommendation emphasized that a required training should have certain minimum components in order to be effective.[16] They also emphasized that the training frequency mattered, because evaluations indicate that youth suicide prevention gatekeeper trainings are effective at reducing suicide rates, but the effectiveness may depend on the frequency of training.[17]

[14] Evaluation by the Substance Abuse and Mental Health Services Administration (SAMHSA).

[15] Session Law 2018-32.

[16] These suggested minimum components were outlined in the 2017 CFTF Annual Report, when this recommendation first appeared on the CFTF Action Agenda, and included: rationale for training that conveys state and national data on suicide deaths and attempts, means, and populations with increased risk; myths and attitudes surrounding suicide; warning signs and symptoms for suicide; identification of students at risk and steps to take for referral; protective factors as prevention; and safe messaging.

[17] An evaluation was done on the effectiveness of youth suicide prevention "gatekeeper" trainings which are trainings for populations such as school personnel that teach recognition of risks and how to appropriately refer for help. Such trainings were found to result in significantly lower suicide rates during the year after the training in the county where the training was implemented as compared to counties that did not implement such a training; however, there was no evidence of an effect beyond one year after training implementation. Walrath, C., Garraza, L., Reid, H., Goldston, D., & McKeon, R. (2015). Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality. Research and Practice, American Journal of Public Health, Vol. 105, No. 5.

2. *Support* for an increase in funding to the School Nurse Funding Initiative by $5 million recurring to add 100 school nurses in high-need communities to move toward meeting nationally recommended ratios.

Currently, the American Academy of Pediatrics recommends having at least one school nurse per school.[18] National recommendations used to address a ratio, which was one nurse per every 750 students. The North Carolina ratio (2017-18 school year) is 1:1055. Under current ratios, a school nurse serves between 2 and 6 schools and may only be in a school for one-half day each week.[19]

The Program Evaluation Division of the North Carolina General Assembly published a report in May of 2017 that addressed the growing need for more school nurses. This report stated that less than half of Local Education Agencies in North Carolina meet the 1:750 ratio, and that to achieve this ratio or to provide a nurse in every school it would cost between $45 million and $79 million annually.[20]

School nurses fill an important role in suicide prevention efforts in schools, while simultaneously addressing overall health and wellness of students, and the complex needs of medically fragile students. School nurses are trained that suicide assessment is among their highest priority roles and responsibilities among many. A national study concluded that school nurses spend 32% of their time providing mental health services to students.[21] School nurses may also screen for abuse or neglect. Most school nurses may be seen without an appointment (unlike many other non-teacher staff in schools) and there is generally no stigma associated with visiting a school nurse.

The NC School Heath Services Survey collects information regarding school nurse involvement with mental health and suicide counseling of students. This is the third year in a row that the CFTF has recommended increased funding to have more school nurses and this chart shows that in three short years, the numbers in this chart have increased significantly in certain categories.[22]

School nurse involvement with mental health and suicide counseling	School Year	Elem. School	Middle School	High School
Known suicide attempts (known to school nurse)	2017-18	68	315	583
	2016-17	76	235	545
	2015-16	32	186	451
Counseling sessions by school nurses related to depression	2017-18	872	1,998	2,612
	2016-17	637	1,495	2,095
	2015-16	636	1,806	2,694
Counseling sessions by school nurses related to other mental health issues	2017-18	4,170	3,641	5,396
	2016-17	2,793	3,155	4,432
	2015-16	2,952	3,138	4,556
Counseling sessions by school nurses related to suicide ideation	2017-18	375	996	791
	2016-17	251	679	615
	2015-16	198	637	657

In just one school year for 2017-18, *NC school nurses reported over 790 counseling sessions on suicide ideation and over 8,000 counseling sessions related to depression or other mental health issues.*

[18] American Academy of Pediatrics, Policy Statement, 2016.

[19] Data source for these statistics: School Health Unit, NC Division of Public Health.

[20] "Meeting Current Standards for School Nurses Statewide May Cost Up to $79 Million Annually," Final Report to the Joint Legislative Program Evaluation Oversight Committee. Program Evaluation Division of the North Carolina General Assembly. May 1, 2017. https://www.ncleg.net/PED/Reports/documents/SchoolNurses/School_Nurses_Report.pdf

[21] Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School Mental Health Services in the United States, 2002–2003.* DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health.

[22] Data source: School Health Unit, NC Division of Public Health.

The 2018 North Carolina state budget included $10 million in *nonrecurring* grants to add school mental health support personnel who were defined as nurses, counselors, psychologists, and social workers. Nurses are therefore one of four types of professionals that schools could hire using these funds, however this funding was available for one year only.

The CFTF specifically recommended increased funding through expanding the School Nurse Funding Initiative (SNFI) because this helps to ensure that nurses are added to high-need communities first. SNFI position allotments are determined through an allocation formula consisting of the following criteria:

1. **School nurse to student ratio**
2. **Economic status of community**
    - Percent of students eligible for free/reduced meals
    - "Low wealth" counties eligible for education supplement
3. **Health needs of children**
    - Infant mortality rate
    - Substantiated child abuse and neglect rate
    - Mortality rates ages 1-19
    - Percent of students with chronic illness
    - Percent of county population that is racial minority
4. **Academic need**
    - Student drop-out rate
    - Percent of schools meeting academic growth targets

Increasing the number of school nurses in communities with the greatest need is a strategy to positively impact overall health and wellness of North Carolina children and their families, and may be viewed as a strategy to help meet Healthy 2020 goals. SNFI requires that funds be spent only on school nurses and where SNFI nurses are assigned, local school districts are not permitted to eliminate other school nurse positions (no supplanting).

---

3. *Endorse* an appropriation of $100,000 in recurring funds for a full-time School Social Worker Consultant to be housed in the Department of Public Instruction Student Support Services to provide coordination, training, support, and data collection for school social workers in North Carolina.

School social workers play a critical role in addressing many barriers children face in getting to school and achieving academic success, and they have an important role in suicide prevention and addressing mental health needs of students.

Currently, there is no state-level position at the Department of Public Instruction (or elsewhere) devoted to school social workers in North Carolina. There is, however, a state level position for school nurses, psychologists, and counselors. Without a state-level position, the ability to coordinate training and resources, provide collaborative opportunities, technical support, or collect data related to efforts and outcomes of school social workers is limited or lacking.

A School Social Worker Consultant at DPI could have a central role in the coordination of a suicide prevention training and protocol requirement in schools (see first suicide prevention recommendation above) and could also have a central role in implementing other types of mental health training that DPI is currently developing.

4. Support state funding for a new statewide firearm safety initiative, as recommended by the 2017 Firearm Safety Stakeholder group, that is focused on education and awareness surrounding firearm safe storage and distribution of free gun locks; funding to go to DHHS to appropriately engage a third-party organization to implement the initiative. (Two-year funding estimate is for $155,700: $86,500 for year one; $69,200 for year two.)

In the most recent ten-year period of 2008-2017, North Carolina lost more than 425 children and youth (age 17 and younger) to firearm-related injuries, with the last five years of that period averaging almost 45 firearm-related deaths per year.[23] In a given year there are four to five times as many firearm-related emergency department visits and hospitalizations (combined) for children and youth as there are deaths.[24]

In North Carolina, over 40% of residents own a firearm yet only about half of NC gun owners and less than half of gun-owning parents keep their gun secured — that is, in a gun cabinet or with a trigger or cable lock.[25] National data and studies tell us this: about one in three handguns is kept loaded and unlocked;[26] most kids know where parents keep their guns;[27] more than 75% of guns used in suicide attempts and unintentional injuries of kids were stored in the home of the victim, a relative, or a friend;[28] and guns used in American mass school shootings often come from home.[29]

Concern about youth access to lethal means was brought to the attention of the CFTF by the State Child Fatality Prevention Team, chaired by the Chief Medical Examiner. This team reviews cases of child deaths and expressed specific concern about youth access to firearms in the context of youth suicide. They recommended formation of a firearm safety stakeholder group to examine firearm safety education and awareness, and the work of this diverse group of stakeholders in 2017 informed the CFTF recommendation for this firearm safety initiative.[30]

In the most recent ten-year period of 2008-2017, ***North Carolina lost more than 425 children and youth*** *(age 17 and younger) to firearm-related injuries.*

[23] Data source: North Carolina Office of the Chief Medical Examiner, NC Division of Public Health.

[24] Data source: Injury and Violence Prevention Branch, NC Division of Public Health.

[25] According to the 2011 North Carolina Behavioral Risk Factor Surveillance System, 41.6% of North Carolina residents own firearms (2011 was the last year this data was collected). Approximately half of North Carolina residents with a firearm reported that the firearm is unsecured (secured = gun cabinet, trigger or cable lock), and 62.5% of residents who are parents left their firearms unsecured.

[26] *Gun Violence: Facts and Statistics*, from the Center for Injury Research and Prevention, Children's Hospital of Philadelphia Research Institute.

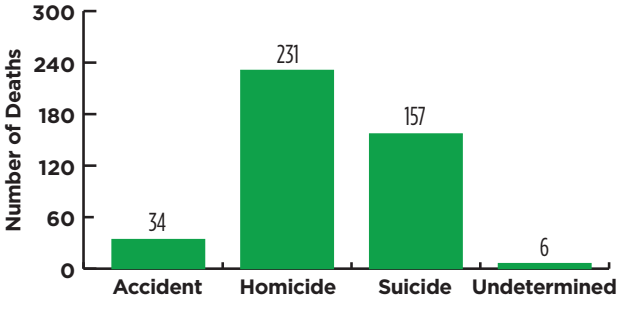
[27] 73% of children under age 10 living in homes with guns reported knowing the location of their parents' firearms. Frances Baxley & Matthew Miller, *Parental Misperceptions About Children and Firearms*, 160 Archives of Pediatric & Adolescent Med. 542, 544 (2006)

[28] Grossman et al., *Self-inflicted and Unintentional Firearm Injuries Among Children and Adolescents*, Archives of Pediatric and Adolescent Medicine, 1999; 153(8).

[29] Giffords Law Center to Prevent Gun Violence: "A report published by the US Secret Service and the Dept. of Education found that in 65% of school shootings covered by the study, the shooter used a gun obtained from his or her own home or from the home of a relative." Report: "The Final Report and Findings of the Safe School Initiative – Implications for the Prevention of School Attacks in the United States." (July 2004). In addition, A Wall Street Journal report in April of 2018 examining nearly three decades of American mass school shootings stated that the killers in these shootings mostly used guns owned by a family member; the report addressed the big role that a lack of gun safety at home has played in school shootings. [Hobbs, Tawnell D. (April 5, 2018). "Most Guns Used in School Shootings Come From Home," *Wall Street Journal*.]

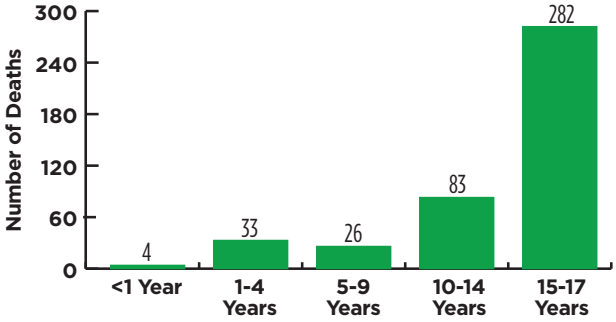
[30] For more information on the work of the stakeholder group, see the 2018 CFTF Annual Report.

YOUTH FIREARM DEATHS IN NORTH CAROLINA BY MANNER, FROM 2008-2017



Source: North Carolina Office of the Chief Medical Examiner

YOUTH FIREARM DEATHS IN NORTH CAROLINA BY AGE GROUP, FROM 2008-2017



Source: North Carolina Office of the Chief Medical Examiner

Funding is needed for this firearm safety initiative to support two years of focused work by a qualified organization (and/or individuals) to launch a statewide initiative with recommended components as follows:

State-level development of a website: A website should be developed (or likely dedicated pages on an existing agency or academic site) where NC citizens and communities can go for information about firearm safety and protecting children and youth from firearm-related deaths and injuries. This website should include, at a minimum:

- Messaging about the importance of safe storage
- Data on firearm-related deaths and injuries to children and youth
- Facts and data related to safe storage of firearms
- A toolkit (see below) for communities to use for firearm safety education and awareness at the local level
- Contact information for obtaining a free or discounted gun lock or lock box
- Information on NC's safe storage laws
- Links to various resources related to firearm safety such as those addressing domestic violence, hunter education, and suicide prevention

State-level development of a firearm safety toolkit: A toolkit should be developed to be used by communities that would include, at a minimum:

- Data related to firearm deaths and injuries to children as well as safe storage of firearms providing context as to WHY this toolkit should be used in communities
- Video PSA that can be distributed for use on social media and beyond
- A flyer and a poster that can be downloaded, printed, and posted with suggested venues for posting
- Contact information for obtaining free or discounted gun locks (if no existing local program for obtaining)
- Suggested structure, content, participants, and media outreach for holding a local gun safety education/ awareness event
- List of the types of stakeholders for communities to involve in firearm safety initiatives
- Contact information to connect with experts who may be able to visit communities to make educational presentations
- Contact information to connect with experts who can offer advice on getting an ongoing firearm safety stakeholder group started in their community

State-coordinated outreach for distribution of toolkits (and gun locks) to local communities: This is an extremely important component of the initiative. Online resources available via the toolkit and website above would be valuable to any community who makes use of them. *However,* those resources are most likely to be used, and used effectively, when community leaders are contacted by a knowledgeable representative of this initiative who brings attention to these resources and offers personal, technical assistance to help launch a local initiative tailored to suit their community's needs. Having a dedicated and skilled person or persons who can do personal outreach and offer technical assistance to communities to help them launch local initiatives is believed to be critical to the success of this initiative.

The formation of an ongoing Firearm Safety Stakeholder Group with diverse representation: Having a diverse group come together regularly to address the issue of firearm safety would help ensure an ongoing focus on this issue.

C. RECOMMENDATIONS TO PREVENT MOTOR VEHICLE-RELATED INJURIES AND DEATHS TO CHILDREN

The leading cause of injury-related death among children in North Carolina is motor vehicle crashes. Among childhood injuries in NC, motor vehicle crashes are the fourth leading cause of hospitalizations and the sixth overall cause of emergency department visits.[31] North Carolina ranks among the highest for all 50 states in terms of medical and work loss costs associated with motor vehicle crash deaths.[32] Recommendations below address two primary risk factors for crash deaths identified by the CDC: not using seat belts and drunk driving.[33]

*The **leading cause of injury-related death** among children in North Carolina is **motor vehicle crashes**. These two Task Force recommendations address two primary risk factors for crash deaths identified by the CDC: not using seat belts and drunk driving.*

[31] Based on data from 2011 – 2014 reported by the Injury and Violence Prevention Branch of the NC Division of Public Health in the *North Carolina Childhood Injury Report: 2011-2014*.

[32] Motor Vehicle Crash Deaths: Costly but Preventable: www.cdc.gov/motorvehiclesafety/statecosts/index.html.

[33] CDC Vital Signs, Motor Vehicle Crash Deaths, July 2016: https://www.cdc.gov/vitalsigns/pdf/2016-07-vitalsigns.pdf.

1. Support legislation allowing for primary enforcement of all unrestrained back seat passengers and increase the fine for unrestrained back seat passengers from $10 to $25.

Currently, NC law requires passengers in all positions of a vehicle to be restrained; however, failure to wear a seatbelt *in the back seat* by those 16 and up cannot be justification for a traffic stop, so it is a "secondary enforcement" (as opposed to primary enforcement) offense.[34] Also, the fine for adults being unrestrained in the back seat is currently $10, while it is $25.50 for the front seat.

According to the National Highway Traffic Safety Administration (NHTSA), primary enforcement seat belt laws lead to higher usage rates, and seat belt use is the most effective way to prevent fatalities and injuries in the event of a motor vehicle crash. In fact, NHTSA has formally urged North Carolina to close this gap in its passenger safety law.[35] In addition, the North Carolina Executive Committee for Highway Safety, chaired by the NC Secretary of Transportation and comprised of leading highway safety experts and stakeholders, approved a resolution in 2018 in support of this recommendation.

The fact that current North Carolina law does not allow for primary enforcement for older teens (age 16 and up) who are unrestrained in the back seat is of special concern to the Task Force because this is a vulnerable age group. In North Carolina, motor vehicle crashes are the leading cause of death for teens ages 15 to 17,[36] and children ages 15 to 18 are significantly more affected by motor vehicle injuries in deaths, hospitalizations, and emergency department visits than other age groups 18 and under.[37] From 2009 to 2013, an average of 52% of teen motor vehicle fatalities in the U.S. were to kids not buckled up.[38]

Data clearly illustrates the dangers of passengers being unrestrained in the back seat, not only causing injury to the person who is unrestrained but to other passengers as well. In North Carolina, a greater percentage of fatal and serious injuries occur to unrestrained rear seat occupants than to unrestrained front seat occupants,[39] and the odds of driver death in the presence of unrestrained rear seat occupants are much higher than when rear seat occupants are restrained.[40] Many may not realize that an unrestrained rear seat passenger can be a source of injury to a front seat passenger in the event of a crash.

Besides the human toll of vehicle crashes there is a large economic toll as well. Enacting primary enforcement of rear seat restraints is expected to result in reduced motor vehicle fatalities in North Carolina that could yield economic savings estimated at nearly $100 million annually.[41]

[34] See N.C.G.S. 20-135.2A(d1) & (e); restraint of children under age 16 is according to G.S. 20-137.1.

[35] Occupant protection assessments for NC are conducted by the National Highway Traffic Safety Administration (NHTSA), and have resulted in the recommendation for primary enforcement of a mandatory seat belt law for all seating positions. In December 2015, the National Transportation Safety Board sent a letter to former Governor McCrory urging enactment of legislation to accomplish this recommendation.

[36] Injury and Violence Prevention Branch, NC Division of Public Health.

[37] Based on data from 2011-2014 reported by the Injury and Violence Prevention Branch of the NC Division of Public Health in the *North Carolina Childhood Injury Report: 2011-2014*.

[38] NC Governor's Highway Safety Program.

[39] NC Governor's Highway Safety Program, data source: North Carolina 2014 Traffic Crash Facts, NC Division of Motor Vehicles.

[40] D. Bose, et al., Accident Analysis & Prevention, Vol. 53, April 2013.

[41] Findley, D., and Nye, T. "Estimating the Effect of Standard Enforcement of Rear Seat Belt Law for Rear Seat Fatality Prevention in North Carolina." Institute for Transportation Research and Education. North Carolina State University. February 1, 2017. Analysis based on NC Dept. of Transportation crash cost data.

2. *Support* legislation that would require ignition interlocks for all DWI offenders.

Alcohol is involved in approximately one-fourth (26.4%) of all fatal crashes in North Carolina. In 2017 in North Carolina, 368 people were killed in alcohol-related crashes.[42]

Each day, 29 people in the United States die in an alcohol-related vehicle crash. Of traffic deaths among children ages 0 to 14 in 2016, 17% involved an alcohol-impaired driver; of child passengers age 14 and younger who died in alcohol-impaired driving crashes in 2016, over half were riding in the vehicle with the alcohol-impaired driver.[43] About one-third of those arrested for impaired driving are repeat offenders.[44] One study showed that the average alcohol-impaired driver has driven under the influence of alcohol over 80 times before their first arrest.[45]

Alcohol ignition interlocks are breath test devices installed in a motor vehicle to prevent operation of the vehicle by a driver who has a blood alcohol concentration over a pre-set low limit. Current North Carolina law makes ignition interlocks mandatory (for restoration of a license after a conviction for driving while impaired) if the person's blood alcohol level is greater than .15 or if the person is a second or subsequent offender.[46] The CDC recommends ignition interlocks as a highly effective strategy to prevent repeat driving while impaired (DWI) offenses while installed, and recommends that interlocks be mandated for *all DWI offenders, including first-time offenders*. Over half of all states now require ignition interlocks for all offenders, but North Carolina is not one of them.

D. RECOMMENDATION FOR SYSTEM SUPPORTS TO MEET THE NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM

Support $50 million in recurring state funding for the effective implementation of Raise the Age legislation.

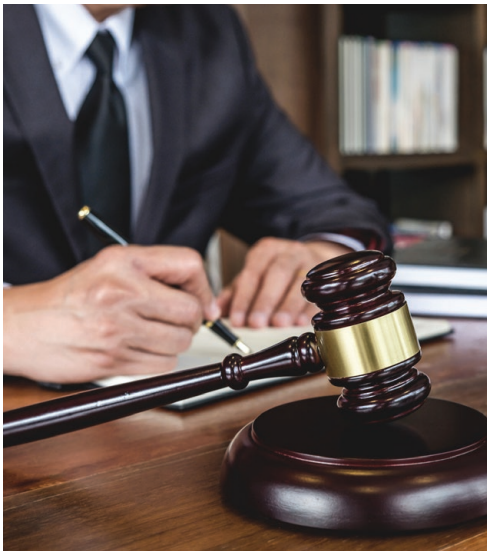
According to the Juvenile Justice Reinvestment Act of 2017, 16 and 17-year-olds charged with most crimes and infractions will no longer go through the adult court system in North Carolina but will instead be dealt with in the Juvenile Court system (this law becomes effective December 1st of 2019).[47] Before this law was passed (commonly referred to as "Raise the Age,") North Carolina was the only remaining state in the U.S. that automatically charged individuals 16 years-old and above in the adult system.

Funding is needed for implementing Raise the Age not only because of the sheer increase in the population of youth that will be served by the Juvenile Justice system (JJ system), but also because of the developmentally appropriate resources and treatment needed to effectively meet the needs of these youth. The mission of the JJ system is "to reduce and prevent juvenile delinquency by effectively intervening, educating, and treating youth in order to strengthen families and increase public safety." Many youths who become involved with the JJ system have multiple needs and may be involved with other public systems. Data indicate that a significant percentage of youth involved in the JJ system have mental

[42] Injury and Violence Prevention Branch, NC Division of Public Health, data source: NC Department of Transportation.
[43] National Highway Transportation Safety Administration.
[44] *Repeat DWI Offenders in the United States*, National Highway Traffic Safety Administration, 1995.
[45] National Department of Transportation, Repeat DWI Offenders in the United States, Feb. 1995.
[46] N.C.G.S. 20-17.8.
[47] The "Juvenile Justice Reinvestment Act" passed as part of the Appropriations Act of 2017, Session Law 2017-57.

health issues, substance use disorders, or a history of victimization and/or involvement with the foster care system.[48] The JJ system is designed to help meet the unique needs of these youth, but must have sufficient resources to do so.

While there has been some funding appropriated to support Raise the Age implementation, the funding needs associated with effective implementation are much greater than what has been appropriated so far. Fully funding Raise the Age elevates our state's ability to meet the needs of this vulnerable population to support their health and safety. (The following information about legislative allocations is from a slide presentation to the Child Fatality Task Force in October of 2018 by the Deputy Secretary for Juvenile Justice, William L. Lassiter.)



E. RECOMMENDATIONS TO PREVENT HARM TO INFANTS AND YOUTH CAUSED BY TOBACCO AND NICOTINE USE

1. *Endorse* additional Quitline NC funding of $3 million.

Quitline NC provides free assistance to help people quit tobacco through: an evidence-based telephone tobacco treatment program; an interactive web-based tobacco treatment program and texting (which can be combined with telephone coaching or stand-alone); coaching calls with highly trained and skilled multilingual coaches; and starter kits of nicotine patches for Medicaid and Medicare recipients and uninsured residents. Studies show that coaching, when combined with FDA-approved tobacco treatment medications, such as nicotine replacement therapy, triples a tobacco user's chances of quitting successfully over quitting without assistance.[49]

Helping people quit tobacco is important for the health of infants and youth. Tobacco use during pregnancy is directly associated with the top causes of infant mortality in North Carolina.[50] Over 1 in 12 babies in North Carolina are born to mothers who report smoking

[48] See presentation to CFTF by Deputy Secretary William Lassiter, October, 2018: https://www.ncleg.gov/DocumentSites/Committees/NCCFTF/Presentations/2018-2019/Raise%20the%20Age%20Lassiter%2010-29-18.pdf

[49] Zbikowski SM, et.al. "North Carolina Tobacco Use Quitline Final Comprehensive Evaluation Reports." Free & Clear, Inc. & Alere Wellbeing Inc. 2006-2016; Fiore MC, Bailey WC, Cohen SJ, et. al. Treating Tobacco Use and Dependence: A Clinical Practice Guideline. US Department of Health and Human Services. Public Health Service, 2008.

[50] University of North Carolina Center for Maternal and Infant Health, You Quit Two Quit, 2018.

during pregnancy; in some counties, over 30% of babies are born to women who smoke.[51] Maternal smoking is also causally associated with ectopic pregnancy and orofacial clefts.[52] As more youth become addicted to nicotine through use of electronic cigarettes (see data in the next recommendation), the need to provide services to help them quit increases.

Not only is quitting important for health reasons, but it also has an economically positive impact. For every dollar spent in FY2011, QuitlineNC provided $2.55 return on investment; however, this was based on coaching services alone, without tobacco treatment medication.[53] This return on investment increases with adequate funds to treat all tobacco users with at least four coaching calls and 8-12 weeks of nicotine patches and gum. Providing NRT and QuitlineNC services increased the State Health Plan's (SHP) return on investment. For every dollar spent, SHP was provided $3.95 return on investment.

2. *Endorse* at least $7 million in funding for youth nicotine use prevention, including e-cigarettes.

Latest available data is that 3 in every ten high school students and one of every ten middle school students use some type of tobacco product.[54] 90% of tobacco users start before the age of 18.

Between 2011 and 2017 current use of electronic cigarettes among NC high school students jumped by 894%, from 1.7% to 16.9% and during the same period, electronic cigarette use among middle school students increased 430%, from 1% to 5.3%.[55] E-cigarettes contain liquids with nicotine that can be bought in thousands of flavors. Nicotine is highly addictive and can harm adolescent brain development; tobacco product use in any form, including e-cigarettes, is unsafe for youth.[56] Devices such as the very popular JUUL e-cigarette, that looks like a flash drive and delivers a high dose of nicotine, have a sleek design attractive to teens who use them for discreet vaping anywhere, including in school.

[51] North Carolina Selected Vital Statistics Vol. 1 2016, NC State Center for Health Statistics.

[52] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[53] Tobacco Prevention and Control Branch and Health and Wellness Trust Fund QuitlineNC Financial Reports. FY11.

[54] NC Youth Tobacco Survey, 2015.

[55] N.C. Youth Tobacco Survey 2011-2017, N.C. Division of Public Health.

[56] U.S. Centers for Disease Control and Prevention.

The U.S. Surgeon General, working with the Centers for Disease Control and the Food and Drug Administration, issued an Advisory on youth use of e-cigarettes on December 18, 2018. This advisory called e-cigarette use among youth an epidemic based on the 2018 National Youth Tobacco Survey showing that e-cigarette use among high school students increased from 11.7 percent in 2017 to 20.8 percent in 2018 as well as 2018 Monitoring the Future national high school study release that showed the spike in e-cigarette use among youth in 2018 is the largest increase in youth drug use in 43 years — since 1975.

The funding being recommended by the Task Force (which would be directed to DHHS, DPH Tobacco Prevention and Control Branch) would support educational programs across North Carolina to reach young people with effective tobacco use prevention messages and programs, leadership training for peer-led and adult-supported tobacco use prevention programs, as well as educational materials and evaluation of data.

F. RECOMMENDATIONS TO STRENGTHEN THE STATEWIDE CHILD FATALITY PREVENTION SYSTEM

The North Carolina Child Fatality Prevention System (CFP System) is large and complex. It was created in 1991 by state statute, and consists of local child fatality review teams in every county (Child Fatality Prevention Teams and Community Child Protection Teams, collectively called "Local Teams"), a state Child Fatality Prevention Team (State Team) led by the Chief Medical Examiner, and the Child Fatality Task Force (Task Force), a legislative study commission that makes policy recommendations and does not conduct child fatality reviews.[57] There is also a State Child Fatality Review Team that reviews certain child maltreatment-related fatalities and utilizes members from Local Teams, but it is addressed in a statute that is separate from the rest of the CFP System.[58]

These groups that are part of the CFP system are each multidisciplinary and cross-sector in terms of their membership. They are comprised of local and state government leaders as well as experts in child health and safety. Participants in the CFP System work to study and understand causes of childhood deaths, advance a communitywide approach to the prevention of child fatalities and child maltreatment, and identify gaps in systems designed to prevent child maltreatment and death. A primary purpose of the CFP System is to make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of children and prevent future child fatalities and maltreatment.

Recommendations stemming from state and local review teams and the Task Force are directed to various entities ranging from boards of county commissioners, local and state-level social services leaders, to the Governor and the General Assembly. In addition, the CFP System is structured for certain information and recommendations to be passed among review teams and the Task Force.

As the following graphics illustrate, the system has many people, parts, and information that are in some ways connected and in other ways disconnected. The fact that the system is complex and has disconnected components makes it challenging even for those working within the system to understand its many moving parts and to coordinate with other parts of the system.

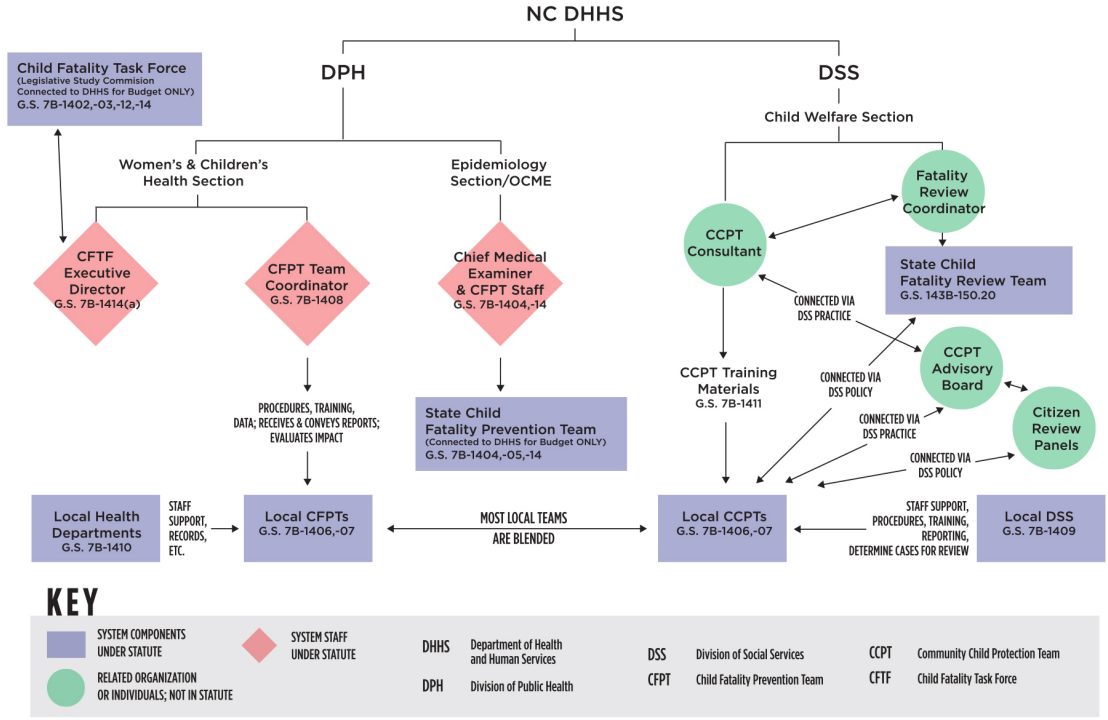
[57] N.C.G.S. 7B-1400 – 1414.
[58] N.C.G.S. 143B-150.20.

HERE IS A GRAPHIC REPRESENTATION OF HOW THE CHILD FATALITY PREVENTION SYSTEM IS CURRENTLY STRUCTURED:

NC CHILD FATALITY PREVENTION SYSTEM STRUCTURE

Explanation of Agency Connections & Responsibilities

(See separate Flow of Information Chart for System Process.)

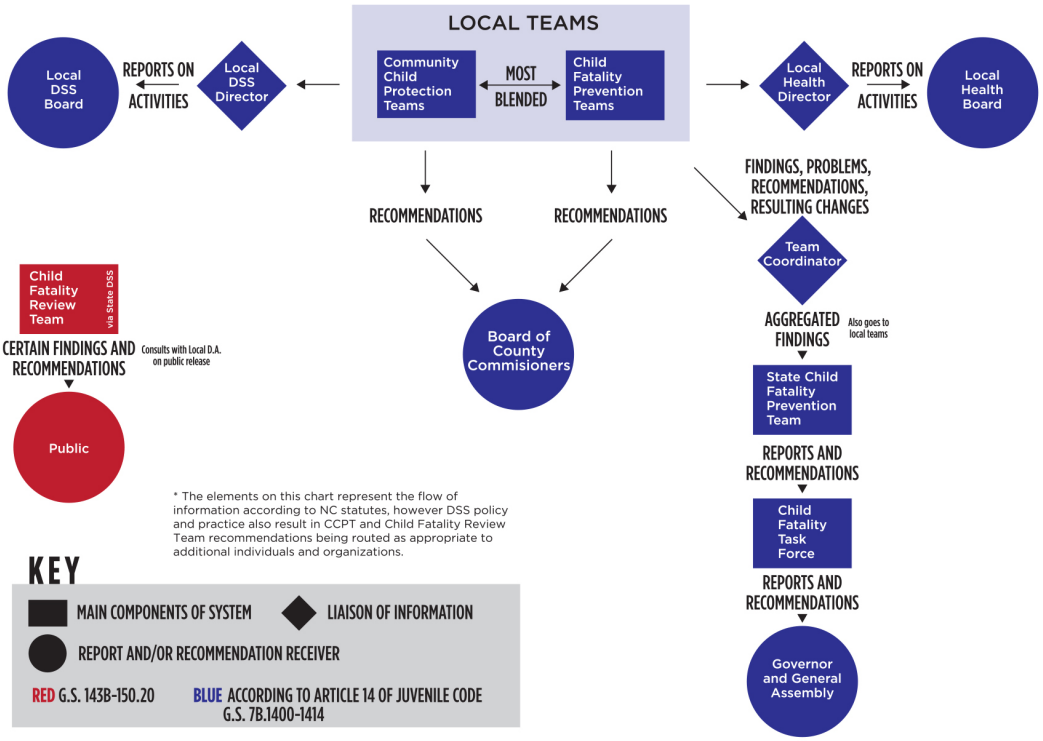


HERE IS A GRAPHIC ILLUSTRATION OF THE FLOW OF INFORMATION WITHIN THE CURRENT CFP SYSTEM ACCORDING TO STATUTES:

NC CHILD FATALITY PREVENTION SYSTEM PROCESS

Flow of information regarding findings, recommendations, or reports according to NC Statutes*.

(See separate Child Prevention System Structure Chart for explanation of agency connections and responsibilities.)



To increase understanding of the overall CFP System by its participants and as a first step to collaborate and strengthen system effectiveness, a two-day event was planned by a committee of volunteers who represented various disciplines and organizations. This event was called the "Child Fatality Prevention System Summit" and was held in April of 2018, drawing over 200 professionals from across the state. At the Summit, participants who were part of local and state groups affiliated with the CFP System had the opportunity to learn from state and national experts, share best practices and challenges, and take part in launching state and local initiatives focused on strengthening the CFP System. (More information about the Summit is available in the CFTF 2018 Annual Report; the 2018 CFTF Action Agenda included an item to administratively support the CFP Summit and for the Task Force to hear information on Summit-related work in the fall of 2018.)

Work addressing the CFP System's strengths and challenges that began at the Summit continued in the months following the Summit. Facilitators from group discussions at the Summit collected and distilled information learned from their groups, and three primary focus areas for strengthening the system were identified: system structure, system data, and support and collaboration for child death review teams of all types. Research was done on other states' child death review systems and on a national data system for child death reviews that is used by 45 other states. Data experts and CFP professionals discussed how data is collected, used, and generated by the CFP System along with desired outcomes for an effective data system. State-level coordinators for local review teams began to work on plans and strategies for new ways to meet the training and resource needs of local teams (see the report from local Child Fatality Prevention Teams on page 60 of this report). National experts in child fatality review and prevention, some of whom presented and participated at the CFP Summit, continued to share information about best practice, other state systems, and the national data system. They also facilitated stakeholder discussions about strengths and challenges of the CFP system and provided feedback on ideas for system improvements.

Outcomes we want to achieve FOR KIDS

- *Ensure that the prevention of child fatalities and maltreatment is approached as a community-wide and state-wide responsibility.*
- *Identify and address system problems or gaps to prevent future fatalities & maltreatment.*
- *Accurately collect and analyze child death data for the purpose of better understanding the apparent and contributing causes of child death and opportunities to prevent future deaths.*
- *Identify effective strategies for the prevention of child fatalities and maltreatment.*
- *Implement effective local and state-level strategies (in the form of programs or changes in law or policy) for the prevention of child fatalities and maltreatment.*
- *Leverage the collaboration and expertise of multidisciplinary teams to draw on public and private resources at the state and local level to accomplish all the above outcomes in order to prevent future child abuse, neglect, and death.*

Meanwhile, the Center for Support of Families (CSF), an organization tasked with making recommendations about many aspects of child welfare including the state's CFP system, released a preliminary report in September 2018 in which it endorsed the process that was undertaken at the CFP Summit and beyond to identify ways to strengthen the CFP System. Findings and recommendations in that report related to the CFP System have significant overlap/alignment with the recommendations from the Child Fatality Task Force that are set out below.[59]

The CFP system has contributed to a 47% decrease in the rate of child deaths since its creation in 1991 through the implementation of local and statewide prevention initiatives as well as the advancement of changes in law and policy. A great deal of time and expertise on the state and local level has been devoted to this work. The Child Fatality Task Force, which has a statutory role in developing this multidisciplinary system,[60] is now making recommendations aimed at strengthening a system that has played such an important positive role in supporting the health and safety of North Carolina's children for twenty-seven years.

The following recommendations are intended as a starting point for system change, as they take into account the necessity of continuing to involve CFP System stakeholders as well as state and national experts in making additional determinations regarding system structure and process that represent best practice but are also logical and feasible. These recommendations are aimed at strengthening the overall Child Fatality Prevention System with the ultimate goal of preventing future child abuse, neglect, and death.

Structural outcomes addressed by these changes

- *Eliminates the "silos" within which the current system functions.*
- *Implements centralized oversight.*
- *Streamlines state-level support functions of CFP System & adds capacity to elevate the effectiveness of all system components.*
- *Eliminates the redundancy/ duplication of team reviews but keeps critical functions & diverse contributions of expertise.*
- *Ensures that review teams have the training and resources they need to conduct effective reviews and make effective recommendations.*
- *Maximizes the usefulness of data/information learned from reviews by expanding, improving, and standardizing data capture, analysis, and reporting.*
- *Ensures that relevant & appropriate information & recommendations from team reviews reaches local leaders, state agency leaders, and the CFTF in a timely fashion.*
- *Ensures that CFTF's ability to study data, evaluate evidence, and advance policies continues.*

[59] The full report from the Center for Support of Families is available at the following link, with recommendations for the Child Fatality Review Process on page 192 (last page): https://files.nc.gov/ncosbm/documents/files/ChildWelfareReform_PreliminaryPlan.pdf.

[60] See N.C.G.S. 7B-1403(2).

1. Support legislation, agency action, and policy change to implement the following changes to the Child Fatality Prevention System (CFP System):

a. Implement centralized state-level staff with whole-system oversight in one location within the Department of Health and Human Services (DHHS) with the formation of a new cross-sector Fatality Review and Data Group.

DHHS, in consultation with those knowledgeable about North Carolina's Child Fatality Prevention System as well as national experts in fatality review and prevention, should determine the most appropriate placement and staffing configuration for this "central office," taking into consideration that most child fatalities relate to issues addressed within the Division of Public Health (DPH). The Fatality Review and Data (FRD) Group, convened by the central office, should act as a liaison with the Child Fatality Task Force (CFTF) for information coming from local fatality review teams and the Office of the Chief Medical Examiner (OCME), with the Chief ME and OCME child fatality staff having a role with this FRD Group. Child fatality staff in the OCME should remain in the OCME and continue to review all child fatalities that come through the medical examiner system. The CFTF should continue to function separately and independently and not as part of DHHS, however staff support functions for the CFTF would be included in the central office and the CFTF report would address whole-system functioning.

The graphic illustration of the CFP System Structure shown above on page 28 provides much of the explanation for why a centralized state-level staff with whole-system oversight is being recommended. The current system has no lead organizational unit or individual. Individuals who are in state-level roles supporting the current system work in "silos" within a structure that is not conducive to interaction or coordination with one another, even though some of their functions overlap. Having a centralized state-level staff connects the CFP System components, streamlining state-level support functions to enable increased efficiency and capacity while also promoting the standardization of tools and resources for all local review teams. The cross-sector Fatality Review and Data Group within this central office would ensure that relevant and appropriate information coming from local review teams and information coming from the Office of the Chief Medical Examiner reaches the state level and the Child Fatality Task Force in particular. The current structure is not optimal for moving information from local teams to the state level, which is further addressed in part II below.

b. Implement a centralized electronic data and information system that includes North Carolina joining 45 other states[61] to participate in the National Child Death Review Case Reporting System.

Central office staff should manage the system and DHHS, in consultation with CFP system stakeholders as well as data and legal experts, should develop and implement appropriate procedures and policies for participation in the national system as well as procedures and policies for appropriate information sharing and protection as it relates to information used by or generated from child fatality reviews. Central office staff should work with NC DSS related to defining, identifying, counting and reporting child maltreatment deaths to align with federal requirements.

The purpose of child death review teams is to collect and produce information that can lead to the prevention of

[61] When this recommendation was originally approved it said "46 other states" but it was subsequently learned that 45 is the correct number of other states participating in the national data system.

future child deaths and maltreatment. If that information is not effectively and appropriately collected, analyzed, shared, and reported, the CFP System and local and state leaders cannot react to what is learned from reviews and function optimally. Under the current system structure, *some* information coming from review teams is targeted to certain entities, but as the diagram of system process on page 28 illustrates, there are gaps and complexities with information flow. In addition, information being generated by four different types of review teams is currently being handled differently by each type of team with four different protocols and/or systems for collecting, managing, analyzing, and reporting on information generated from reviews, and these four systems are not connected. Part IV of the recommendation below would remedy having four different types of information systems by consolidating four different types of teams into one. Having centralized management and protocols addressing data and information would help ensure the effective and appropriate handling of information statewide, including making sure that reports are being produced and that appropriate information is reaching the relevant entities and the public when appropriate.

The use of one electronic data system would also strengthen the effective and appropriate handling of information. A data system used by 45 other states to manage child death review team information is the *National Child Death Review Case Reporting System*.[62] This system is a standardized case report tool available to states at no cost through the National Center for Fatality Review and Prevention, who offers technical assistance for all users – also at no cost. Through this web-based system, local and state users can enter case data, findings, and recommendations. They can access and download their data, perform data analysis, and develop their own reports. Use of the national system would not only standardize, modernize, and streamline data collection in North Carolina, it also promotes gathering richer layers of data than what is currently collected by most types of review teams, which in turn allows for a strengthened ability to analyze and understand what is happening in North Carolina to inform prevention initiatives and policy change.

c. Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities.

Teams should be required to review the following types of deaths: undetermined causes; unintentional injury; violence; motor vehicle incidents; child abuse or neglect/ child protective services involvement; sudden unexpected infant death; suicide; and deaths not expected in the next 6 months. Teams could choose to review other types of deaths as well. In addition, DHHS, in consultation with child fatality review and prevention experts as well as perinatal health experts, should determine: 1) any additional special criteria that should be used for determining which types and/or percentages of infant deaths (which account for two-thirds of all child deaths) should be reviewed by teams in order to optimize the identification of prevention opportunities; and 2) area(s) of North Carolina in which a specialized Fetal and Infant Mortality Review (FIMR) program should be launched and integrated with the larger CFP System to inform state-level action related to the prevention of infant deaths (dependent on available funding).

[62] For more information about the national system, visit the following page on the website for the National Center for Fatality Review and Prevention: https://www.ncfrp.org/resources/national-cdr-case-reporting-system/.

North Carolina is the ninth most populated state and in 2016 had a total of 1,360 child deaths and in 2017 had 1,313 child deaths. There are very few other states that do team reviews of literally all child deaths. Reducing the number of deaths reviewed by teams to those most likely to yield identification of system problems and/or prevention opportunities allows for optimization of CFP efforts system-wide. These recommended categories of minimum causes of death to be reviewed resulted from consultation with national experts about best practice for categorizing deaths to be reviewed when a state is not reviewing all deaths. Special procedures and/or additional criteria for case selection may be needed for reviews of infant deaths. Infant deaths make up two-thirds of all child deaths in North Carolina and it is important that the CFP System is optimized to focus effectively on this population to help reduce North Carolina's infant mortality rate, which is among the highest dozen in the nation.

Fetal and Infant Mortality Review programs utilize a model of fatality review that has evolved over the past few decades, and currently there are 176 FIMR programs in 28 states, but not in North Carolina.[63] FIMR utilizes team reviews that have many overlaps with other types of child death reviews, however there are different procedures and participants that require a great deal more staff support with specialized expertise, and therefore more resources, than what is required for current reviews of infant deaths in North Carolina. The FIMR process uses trained health care experts (often nurses) to gather, analyze, and synthesize case information from various sources, especially health care records. FIMR also utilizes trained professionals (which can be the same or a different person) to conduct in-person interviews with the mother and/or family of the child. The in-person interview is a very valuable aspect of the process that distinguishes it from other types of reviews. Information collected from records and interviews is prepared by staff and brought to the review, and unlike most fatality reviews, case information is de-identified prior to team review. Given the degree of resources required to implement FIMR, it would not be feasible to implement it on a statewide basis, but implementation in one or more communities could be valuable to inform both local and state-level actions for prevention.

d. Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one with different procedures and required participants for different types of reviews; these teams would be local but have the option to choose whether to be single or multi-county teams. DHHS should study and determine an effective framework for meeting the federal requirements for Citizen Review Panels and for reviewing active DSS cases.

Intensive-type reviews for fatalities related to suspected abuse or neglect or families involved with DSS should still take place with coordination and technical onsite assistance from state-level staff. DHHS, in consultation with child welfare and child fatality experts, should determine appropriate policies, procedures, and required participants for these types of intensive reviews, whether there should be distinct and special procedures or required participants for certain other types of deaths reviewed, and whether and under what circumstances the Fatality

[63] Data source and source for other information on FIMR is available via the presentation on FIMR given to the Perinatal Health Committee of the CFTF by a national expert from the National Center for Fatality Review and Prevention: https://www.ncleg.gov/DocumentSites/Committees/NCCFTF/Perinatal%20Health/2018-2019/Presentations%20and%20Handouts/FIMR%20Fournier%2011.26.18%20NC.pdf

Review and Data Group (referenced above in part I) should have the ability to do occasional state-level team reviews with the involvement of the OCME. The Chief Medical Examiner and OCME child fatality staff would no longer be leading routine State CFPT reviews but they would continue to perform all other current functions related to child fatalities that enter the ME system, they could contribute information to local team reviews, they would perform case analysis and reporting that they contribute to the new Fatality Review and Data group and to the larger system, and they would work closely with the CFP central office. Citizen Review Panels should no longer be combined via policy with all local Community Child Protection Teams, and active DSS cases (not involving a fatality) should not be required by statute to be reviewed by local teams who review fatalities.

The current North Carolina system has four different types of review teams: the State Child Fatality Prevention Team, local Child Fatality Prevention Teams, local Community Child Protection Teams, and the State Child Fatality Review Team. Local teams are in every county and in many counties, the two types of local teams operate as a combined team, which means they can conduct reviews together, but other things remain separate, such as state and local agency support and training, reporting requirements, and systems for collecting information from reviews. Under the current system structure, three different types of teams may end up reviewing the same child death, while it is common for two different types of teams to review the same death of many other types.[64]

Other states' child death review systems vary quite a bit in terms of structure and operation, but national experts have observed that North Carolina's current structure is *the most* complex state system. Besides having many types of review teams, North Carolina's structure of having three types of state-level groups is also unique. In other states, there is typically one state-level group that performs some functions similar to North Carolina's current State Child Fatality Prevention Team and state Child Fatality Task Force combined. However, most state-level groups do not perform reviews when reviews are performed by local teams. Rather, they serve in more of an advisory capacity to local review teams and they focus on information coming out of the local teams and on policy. When state groups do conduct reviews, they are typically not routine, but only in certain circumstances.

This recommendation to consolidate the four types of teams into one team removes duplication of efforts, with the goal of getting all the very best information available for one case in front of a team for one effective review. The best information is often available at the local level, which is why this recommendation focuses on local teams. This does not change the fact that child fatality staff in the Chief Medical Examiner's Office review all child deaths that come into the Medical Examiner System and local teams can incorporate into their reviews appropriate state-level information as well. If it is determined that state-level team review is needed under certain circumstances, the new Fatality Review and Data Group can be structured to accommodate this purpose, with involvement from the Office of the Chief Medical Examiner.

An important aspect of this recommendation is the need to structure local teams so that the procedures and required participants can be adjusted

[64] Under the current system, a death that is related to abuse or neglect (under certain circumstances) is to be reviewed by the State Child Fatality Prevention Team, the local Community Child Protection Team, and the State Child Fatality Review Team. Many other cases will be reviewed by a local Child Fatality Prevention Team and the State Child Fatality Prevention Team.

*Under the current system structure there are **four types of review teams**, three of which may end up reviewing the same child death related to abuse or neglect, and two of which may review many other types of deaths.*

to most effectively address the type of death being reviewed. This ensures that important aspects of the work done by current teams are not lost in this consolidation while allowing for procedures and participants that are optimal and most efficient for the type of death being reviewed.

For example, review of a death that is related to abuse or neglect where the family had a connection to social services can have such special procedures and participants that are similar to what is currently undertaken by the State Child Fatality Review Team. These reviews are currently referred to as "DSS Intensive Reviews" and although they are currently led by state-level DSS staff, they utilize local team members for their team and are longer and more in-depth reviews than the types of reviews performed by other teams, with a different process and procedures. These types of reviews can continue to receive state-level technical assistance and continue to be longer and more in-depth to appropriately and fully address and report on these types of cases (these reviews currently report certain findings publicly and there is nothing about this recommendation that suggests that should change). It may also be appropriate to designate special procedures and/or participants for certain other types of deaths – for example certain infant deaths (see part III above related to the importance of doing effective reviews of infant deaths).

This recommendation would allow for counties to choose whether to have a single-county team or combine with other counties for a team, a practice that is done in some other states. Some larger more urban counties who have larger numbers of child deaths may choose to have a single-county team. However, there are rural areas of the state with small populations and very few deaths, and counties in these types of areas may find that it is more efficient and effective to have a combined team.

Under this recommendation, Citizen Review Panels (CRPs) would no longer be combined with all local review teams and local teams would no longer be reviewing active DSS cases. Federal law requires states to have a minimum of three CRPs and by DSS policy (not by statute), all 100 county Community Child Protection Teams (CCPTs) in North Carolina have been designated as CRPs. Although there is some overlap, CRPs have different required members and functions as compared to current local review teams. For CRPs and fatality review teams to function most effectively and adhere to their individual purposes and requirements, it is not optimal for CRPs to be combined with all teams. It is also not optimal with respect to participants and procedures to structure all fatality review teams to also review active DSS cases, as is currently done in local CCPTs.

e. Formalize the three committees of the Child Fatality Task Force (CFTF) with certain required committee members and expand the required CFTF report to address the whole CFP system with required report to be distributed to additional state leaders beyond the Governor and General Assembly.

Formalize the existence, functioning, and membership of the three committees of the CFTF with CFTF Executive Committee determination for how CFTF members will be assigned to specific committees, whether there should be additional members, and other policies that impact the effective functioning of committees. With connections between the CFTF and fatality reviews being strengthened in this restructuring, the annual report the CFTF currently submits to the Governor and General Assembly should be expanded to address the whole CFP system, as the CFTF serves in an advisory role to the CFP Central Office to help ensure whole-system effectiveness. The CFTF report should be submitted to additional state leaders such as certain legislative committees and agency leaders whose work impacts child health and safety.

The Child Fatality Task Force has for much of its twenty-seven-year existence found successful functioning by structuring its work through three committees: Perinatal Health, Unintentional Death Prevention, and Intentional Death Prevention. More formally defining these committees and requiring certain committee members ensures consistent expert and agency input and member attendance in committee meetings.

The CFTF is currently required to submit an annual report to the Governor and General Assembly addressing its own functions and responsibilities. Other groups within the system are not currently required to submit an annual report.[65] Under the above recommendations, components of the system would be more connected, and it would therefore be appropriate and meaningful for this annual report to address not only the work of the CFTF but the work of the system as a whole. Having the report submitted to additional state leaders would increase knowledge about the issues addressed in the report as well as the likelihood of successful implementation of policies and initiatives to prevent child deaths and maltreatment.

---

2. Maintain current state funding for existing positions and operations that support Child Fatality Prevention System work, and pursuant to DHHS determinations to be made related to the most appropriate placement and staffing configuration for this central office as well as funding needs of local health departments to support CFP system work, appropriate additional recurring funding to support this work. (Funding estimate is for $550K.)

---

3. Pursuant to DHHS determinations to be made related to launching a Fetal and Infant Mortality Review Program to inform state-level action related to the prevention of infant deaths (see III above), support funding to enable implementation of the evidence-informed practice of FIMR as a pilot. (Funding estimate is for $300K.)

[65] The CFTF annual report has frequently included brief reports addressing work of the State and Local Child Fatality Prevention Teams.

Legislative History and Accomplishments

Every year since its creation in 1991, the North Carolina Child Fatality Task Force has helped achieve legislative victories for children. The following list is organized by year and includes most — but not all — of the legislative accomplishments of the Child Fatality Task Force. Many of these accomplishments were led by the Task Force; for some, the Task Force was one of a number of organizations advancing the item.

1991

North Carolina Child Fatality Task Force established. The Task Force, a diverse legislative study commission, was charged to study the incidence and causes of child death as well as to make recommendations for changes to legislation, rules, or policies that would promote the safety and well-being of children. The Task Force was also charged to develop a system for multi-disciplinary review of child deaths.

Community Child Protection Teams (CCPTs) established. CCPTs were established in each county by Executive Order. Each CCPT has the responsibility to review selected active Child Protection Services cases of the county Department of Social Services and review all cases in the county in which a child died because of suspected abuse and neglect. The purpose of these reviews is to identify gaps and deficiencies in the community child protection system and safeguard the surviving siblings.

North Carolina Child Fatality Review Team (State Team) established. The State Team, a multi-agency panel, was directed to review all cases of fatal child abuse, all deaths of children known to Child Protective Services before their deaths, and additional cases of child maltreatment. The purpose of the reviews is to discover the factors contributing to child fatalities in North Carolina. The State Team is required to report to the Task Force and to recommend legislation to prevent child deaths.

1992

North Carolina Child Fatality Task Force membership expanded to include members of the General Assembly. Two Senators and two members of the House of Representatives, as well as one local health director, were appointed.

North Carolina Child Fatality Task Force extended to 1995.

Additional funds appropriated for Child Protective Service Workers. The Task Force requested $5 million, with a plan to request a total of $30 million over several years. The bill also called for a study of the financing of CPS positions in county Departments of Social Services. The General Assembly appropriated $1 million.

Pilot programs for Family Preservation Services funded. The General Assembly appropriated $410,000 for the Basic Social Services plan in three to five counties as pilots, and $50,000 to develop and implement model programs of locally-based Family Preservation Services.

Study of Child Protective Services funded. The General Assembly appropriated $80,680 to conduct a study to determine a method that would ensure accountability by the county Child Protective Services programs, to ascertain the best management structure for Child Protective Services, and to determine the need for stronger state supervision of county programs.

"Hot Lines" established. The General Assembly appropriated $62,000 to establish 24-hour Protective Services "hot lines" in each county.

Additional funds for the Child Medical Evaluation Program appropriated. The General Assembly appropriated $935,750 for the Child Medical Evaluation program, $180,000 of which was allocated for a backlog of claims for services and was non-recurring.

Protocols required. The legislation directed the State Division of Social Services to ensure that community interdisciplinary teams develop protocols for use in child abuse and neglect reviews.

1993

Local Child Fatality Prevention Teams (CFPTs) established. Local CFPTs were directed to review all child deaths in each county unless the death was already under review by the local Community Child Protection Team (CCPT). Since each county now had two community-based teams, the local CFPT and CCPT were given the option of joining together or operating independently. The multi-agency membership for the local teams was established by state statute.

Child Fatality Task Force specifically charged to study the incidence and causes of child abuse and neglect.

Additional funds for Child Protective Services Workers appropriated. The General Assembly appropriated $2 million, but maximum caseload standards were not established by statute.

Committee established to develop a payment plan for the evaluation of maltreated children. The resulting committee recommended funding regional maltreatment resource centers.

NCGA Chapter 7A revised. Changes include creating the duty to report and investigate child dependency as well as child abuse and neglect; requiring county Department of Social Services directors, upon receiving a report about a child's death because of suspected child maltreatment, to ascertain immediately whether there are other children in the home; improving information sharing; and mandating that child fatalities from alleged maltreatment be reported to the State Division of Social Services Central Registry.

Driving While Impaired (DWI) law amended. The amended statute provides that the presence of a child under 16 years of age in a vehicle driven by a person convicted of a DWI violation shall be considered a grossly aggravating factor in sentencing.

Funding for student services personnel provided. The General Assembly appropriated $10 million for school counselors, to fulfill a provision of the Basic Education Plan.

Comprehensive health screening for kindergarten students mandated. This law requires each child to have a comprehensive health screening evaluation by the time he or she enters kindergarten.

1994

Six additional members of the General Assembly appointed to the Task Force. Three Senators and three members of the House of Representatives were appointed.

North Carolina Child Fatality Task Force extended to 1997.

Family Preservation Program expanded. The General Assembly appropriated $500,000 to expand this program.

Prosecutorial child protection law passed. This law provides for bail and pretrial release conditions determined by the judge in child abuse cases. It also provides for children to be made comfortable in courtrooms during child abuse cases.

Child passenger safety law strengthened. This law requires children under 12 to be safely restrained while riding in a car, whether they sit in the front or the back seat. Infants and toddlers under age four must be secured in child safety seats; older children must use seat belts.

The following laws were passed during the Special Session on Crime called by the Governor in 1994:

The Task Force supported several components of the Governor's crime package of legislation that applied to juveniles: **Family Resource Centers, Wilderness Camps, the Mentor Training Program for Coaches, and the Governor's One-On-One Program.**

The Task Force worked to amend a bill calling for a comprehensive study of the Division of Youth Services' Juvenile Justice System. The amendment provided for **diagnostic assessments of all youth in state training schools** to determine that each youth has been properly placed.

Community-Based Alternatives program funded. The General Assembly appropriated $5 million for programs that are intended to reduce the number of youths committed to training schools by rehabilitating these troubled youths in their communities.

The Task Force also worked to increase **the penalty for illegally selling guns to a minor from a misdemeanor to a felony.** This felony charge for a weapons violation enables law enforcement to aggressively prosecute those who illegally sell firearms to minors.

1995

Training for child sexual investigations initiated. The Task Force requested $125,000 for statewide, multidisciplinary training for child sexual abuse investigations. The training was funded for $38,336 recurring and $5,000 non-recurring funds through the State Bureau of Investigation.

Underage drinkers prohibited from driving. The Task Force endorsed legislation requiring "zero tolerance" for alcohol measured in the blood or breath of drivers 18 to 20 years old.

Smoke detectors required in all rental property. This law filled in a gap in North Carolina's smoke detector laws by requiring landlords to install operable smoke detectors for every dwelling.

Sale of fireworks to children prohibited. Before 1993, the sale of pyrotechnics was illegal in North Carolina. In 1993, the General Assembly allowed the sale of some pyrotechnics. The Task Force sought to repeal these changes to the pyrotechnics law in 1995. The General Assembly did not repeal the 1993 law, but a bill was passed that restricts the sale of those pyrotechnics to persons over the age of 16.

Adoption proceedings moved from Superior to District Court. The Task Force sponsored this legislation as a first step toward creating a comprehensive family court system in North Carolina.

1996

Child abduction law strengthened. This law applies the penalty for abducting a child from a parent, guardian, or school or abductions from any agency or institution lawfully entitled to the child's custody.

1997

Dependent juvenile definition changed. The old statute defined a juvenile as dependent if his or her parents were unable to provide care "due to physical or mental incapacity." This language did not make provision for other situations, such as one in which one or both parents are incarcerated. This law broadened the definition of dependent juvenile and enabled hundreds more children to receive help from the Department of Social Services.

Intensive Home Visiting partially funded. The Task Force had a standing goal of encouraging the state to appropriate $3.2 million for intensive home visiting programs that have been shown to be effective in reducing the incidence of child abuse and neglect, unwanted pregnancy, and juvenile involvement with the courts. In 1997, the General Assembly appropriated $825,000 for home visiting, with an additional $200,000 in 1998.

Graduated Driver's License mandated. This measure gives new teenage drivers more experience — and a greater chance of survival — as the result of a three-step process for obtaining a driver license. This ensures that beginning drivers get a full year of supervised practice driving with a parent. It also restricts night-time driving for new licensees during the first six months of unsupervised driving.

1998

Sunset of the Task Force lifted.

Court Improvement Project launched. To reduce the amount of time that children are in foster care, the Task Force supported legislation to change the process for handling abuse and neglect cases. Because of this legislation, termination of parental rights may now be a motion in the cause, adjudication must take place within 60 days of the filing of the petition, the first hearing must be at 90 days, and the second hearing within six months.

Smoke detector penalty set. This law sets a $250 penalty for landlords who fail to install smoke detectors in rental units and a $100 penalty for tenants who destroy or disable smoke detectors after they have been installed.

1999-2000

Child passenger safety law strengthened. The passage of Senate Bill 1347 will save an estimated five lives and 45 serious injuries among child passengers aged 16 or younger each year. The new law imposes a two-point driver's license penalty on drivers who do not see that young passengers are in age-appropriate safety restraint. The enactment of this law closes one of the last remaining gaps in the state's motor vehicle passenger safety laws.

Juvenile procedures clarified. Passage of House Bill 1609 will help move children from abusive, dangerous environments toward safer, permanent homes. The old law required that parents be given separate notices of the possible termination of their parental rights, even if termination is clearly best for the child. This measure streamlines the legal process while preserving parents' rights to proper notification.

Guardianship strengthened. Sometimes called "soft adoption," guardianship is a good option for some children who need a safe, nurturing home. Passage of Senate Bill 1340 clarifies the rights and duties of a legal guardian and thereby creates a more stable home for children with court-appointed guardians.

2001

Infant Homicide Prevention Act passed. House Bill 275 created a safe haven for newborns who would otherwise be abandoned by their distraught mothers.

Child Bicycle Safety Act passed. House Bill 63 established that bicycle riders age 15 and younger must wear an approved helmet when riding on public roads and rights-of-way.

Child Fatality Task Force 10-Year Anniversary celebrated. In the ten years of the Task Force's existence, the child death rate in North Carolina dropped approximately 20 percent. At 76.4 deaths per 100,000 children, North Carolina experienced the lowest child fatality rate it had ever recorded.

2002

"Kids First" license tags issued. The General Assembly and the Division of Motor Vehicles authorized and issued "Kids First license tags with the proceeds going the North Carolina Children's Trust Fund.

Key programs continued. During a time of intensive budget cuts, the Intensive Home Visiting program, the Healthy Start Foundation, the folic acid campaign, and the birth defects monitoring program all received continued funding. **Graduated Driver Licensing system improved.** A provision was added to the existing system which limits the number of passengers under age 21 that a novice driver may transport during the first six months of unsupervised driving (allowing only one young, non-family member).

2003

Safe Surrender supported. Task Force members lent their support to the Division of Public Health who was successfully awarded a grant from the Governor's Crime Commission for FY '03-'04 to increase public awareness of the Infant Homicide Prevention Act (aka NC Safe Surrender Law).

2004

NC Booster Seat Law (Senate Bill 1218) ratified. The law established that a child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags. If no seating position equipped with a lap and shoulder belt to properly secure the weight-appropriate child passenger restraint system is available, a child less than eight years of age and between 40 and 80 pounds may be restrained by a properly fitted lap belt only.

Endorsed. The Task Force endorsed: Strengthening penalties when methamphetamine is manufactured in a location that endangers children.

2005

All-Terrain Vehicle Safety Law (Senate Bill 189) ratified. The law established that a child less than eight years of age is not allowed to operate an ATV. In addition, the law creates restrictions based on age and machine size for children between the ages of eight and 16. The law also requires adult supervision for children under 16, restricts passengers to those ATVs designed for more than one person, bans operation on public streets,

roads and highways, and outlines equipment standards for sellers and buyers. In addition, safety training is now required for operators as is the use of safety equipment.

2006

Unlawful Use of a Mobile Phone Law (Senate Bill 1289) ratified. The law established that children under the age of 18 cannot operate a motor vehicle while using a mobile phone or any technology associated with mobile phones. Exceptions were created for teens talking with their parents, spouses or emergency personnel.

Rear Passenger Safety Law (Senate Bill 774) ratified. The law requires use of rear-seat safety belts by all passengers of non-commercial vehicles.

Strengthen Sex-Offender Registry Law (House Bill 1896) ratified. The law strengthened North Carolina's existing sex offender registry system by requiring additional standards for monitoring sex offenders, including extensive monitoring of the most predatory offenders upon their release from prison.

Funds to Prevent Child Maltreatment (Senate Bill 1249) appropriated. $90,000 in recurring funds was allocated to the Department of Health and Human Services for one position to staff the Child Maltreatment Leadership Team and carry forth recommendations of the North Carolina Institute of Medicine's Task Force on Child Abuse Prevention.

General Statute 7B-302 DSS Disclosure of Confidential Information (Senate Bill 1216) amended. The amendment clarified the ability of county Departments of Social Services to share confidential information with other professional entities. The amendment also put North Carolina in compliance with federal child welfare funding guidelines and allowed for continued federal support.

Funds to Prevent Preterm Births (Senate Bill 1741) appropriated. $150,000 in non-recurring funds was allocated to provide medications to low-income women at-risk of a second premature birth. The medication is proven to reduce recurring preterm births by 33 percent.

Funds to establish a Perinatal Health Network (Senate Bill 1253) appropriated. $75,000 in non-recurring funds was allocated for the creation of a professional perinatal health network. The network will bring together perinatal health leaders to plan strategically for the reduction of infant mortality and promotion of women's and infants' health in North Carolina.

Endorsed. The Task Force endorsed: 1) continuing the Medicaid Family Planning Waiver; 2) recurring funding of the North Carolina Folic Acid Campaign at $300,000; 3) recurring funding for the North Carolina Healthy Start Foundation for statewide infant mortality reduction initiatives and conversion of non-recurring funding to recurring funding status; 4) recurring funding for the North Carolina Birth Defects Monitoring Program at $325,000.

Administrative changes recommended. 1) support the North Carolina Division of Public Health efforts to procure grant funds for youth suicide prevention; 2) form a CFTF subcommittee to work on gun safety, specifically pursuing a gun safety awareness campaign, creating talking points on gun safety, and seeking common ground to prevent injury and death to children and youth due to firearms.

2007

Child Passenger Safety Exemption (Senate Bill 23) ratified. Amended § 20-317.1. (Child restraint systems required), by removing exemption (b) ii "when the child's personal needs are being attended to" to qualify North Carolina for the continuation of $1 million in child passenger safety funding from the National Highway Traffic Safety Administration.

Funds to address infant deaths secured. Appropriations recommended by the Child Fatality Task Force were secured and included: $97,000 in non-recurring funds to prevent preterm births by providing the medication known as 17-Progesterone to uninsured women, and $150,000 in non-recurring funds for a statewide Safe Sleep awareness campaign.

Endorsed. The Task Force endorsed: 1) $200,000 in recurring funds were provided for the birth defects monitoring system; 2) $150,000 in non-recurring funds were provided for the North Carolina Healthy Start Foundation; 3) the Fire Safe Cigarette Act (House Bill 1785) passed and requires cigarette manufactures to produce and market only cigarettes that adhere to an established cigarette fire safety performance standard.

Legislative charge received. Senate Bill 812 directed the Child Fatality Task Force to study issues relating to requiring the installation and use of passenger safety restraint systems on school buses and report findings by May 2008.

2008

Amend Child Abuse (Senate Bill 1860) ratified. An act to increase the criminal penalty for misdemeanor child abuse and to amend the criminal offense of felony child abuse.

Hospital Report Child Injuries (House Bill 2338) ratified. An act to require hospitals and physicians to report serious, non-accidental trauma injuries in children to law enforcement officials.

Funds to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funds to reduce infant deaths secured. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

Child Passenger Safety Technician Liability (House Bill 2341) ratified. An act to limit liability for the acts of certified child passenger safety technicians and sponsoring organizations of child safety seat educational and checking programs when technicians and sponsoring organizations are acting in good faith and child safety seat inspections, installation, adjustment or education programs are provided without fee or charge.

Require Carbon Monoxide Detectors (Senate Bill 1924) ratified. An act to authorize the North Carolina Building Code Council to adopt provisions in the Building Code pertaining to the installation of carbon monoxide detectors in certain single-family or multifamily dwellings; to require the installation of operational carbon monoxide detectors in certain residential rental properties and to provide for mutual obligations between landlords and tenants regarding the installation and upkeep of carbon monoxide detectors.

Transporting Children in Open Bed of Vehicle (House Bill 2340) ratified. An act to increase the protection of children who ride in the back of pickup trucks or open beds of vehicles by raising the minimum age to 16 and removing the exemption that made allowances for small counties.

Change Format of Driver Licenses/Under 21 (House Bill 2487) ratified. An act to change the format of a driver license or special identification card being issued to a person less than twenty-one years of age from a horizontal format to a vertical format to make recognition of underage persons easier for clerks dealing in restricted age sales of products such as alcoholic beverages and tobacco products.

2009

Funding to prevent preterm births provided. $97,000 in non-recurring funds appropriated to continue efforts to provide minority and low-income women at-risk for delivering a premature infant with a preventative treatment to reduce the risk of a recurring preterm birth.

Funding to reduce infant deaths provided. $150,000 in non-recurring funds appropriated to continue funding for a statewide public awareness campaign to promote safe sleep and reduce infant deaths due to Sudden Infant Death Syndrome (SIDS) and unintentional suffocation/strangulation.

The Division of Medical Assistance directed to explore interconceptional care. This direction allows DMA to pursue a federal waiver or other mechanism to offer a basic package of interconceptional care services to low-income women at high-risk for delivering prematurely.

Funding continued for Child Medical Evaluation System. This system provides diagnostic services to children suspected of being victims of child maltreatment.

Interagency agreements established to better protect children from violent sex offenders. The federal Adam Walsh Child Protection and Safety Act requires a more comprehensive, nationalized system for registration of sex offenders. To meet this goal, interagency collaboration has been established between the State Bureau of Investigation, the Sheriff's Association, the Division of Social Services (DSS) and others.

An Act to Prohibit the Retail Sale and Distribution of Novelty Lighters (Senate Bill 652) ratified. This act to protect children by banning the sale of novelty lighters.

The Nicholas Adkins School Bus Safety Act (House Bill 440) ratified. This measure assures that pictures taken of drivers committing a stop arm violation are acceptable evidence for conviction and makes it a felony if a student is killed due to an illegal pass of a stopped school bus.

Youth employment protections passed. Enhance Youth Employment Protection Act (H22) enhances reporting and surveillance requirements by the Department of Labor. Strengthen Child Labor Violation Penalties (H23) increases penalties to employers who violate child labor requirements.

2010

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the Task Force focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Folic Acid/Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $325,000 for the Eastern Carolina University High-Risk Maternity Clinic to improve birth outcomes in Eastern North Carolina; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $97,000 for 17-Progesterone distribution to help prevent pre-term births; $408,000 for the Healthy Start Foundation to improve maternal health prior to and during pregnancy.

Increase Driver's License Restoration Fee (S655) ratified. This act increases the fee that drivers who have their licenses suspended following conviction for impaired driving must pay to have their licenses later restored. All funds raised (an estimated $560,000 each year) will go to Forensics Tests for Alcohol to continue programs to deter, detect and convict impaired drivers.

2011

Funding to preserve infant mortality prevention infrastructure maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to

their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $150,000 for Safe Sleep to avoid SIDS and other sleep-related deaths; $47,000 for 17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant.

Fine for speeding in a school zone increased to $250 (S49). Speeding just an extra 10 mph in a school zone greatly increases the chance of death for a student hit by a car. The chance of pedestrian death increases 9-fold (from 5% to 45%) with an increase in speed from 20 mph to 30 mph. This bill makes the fine for speeding in a school zone equal to that of speeding in a construction zone.

Sale of certain dangerous synthetic substances banned (S7). This act bans substances previously available legally including a synthetic cannabinoid that produces a marijuana-like high and MDPV, a synthetic that produces a cocaine-like high and hallucinations. The ban went into effect June 1, 2011. Throughout the early implementation period, the CFTF has worked with law enforcement and others to monitor the effectiveness of the ban.

Penalty for driving impaired with a child in the car enhanced (S241). Motor vehicle crashes are the leading injury-related cause of death for children and impaired driving is a factor in 15% -20% of those deaths. National data show that most children who die in crashes where alcohol is involved are the passenger of the impaired driver. Additionally, impaired drivers are also less likely to buckle-up their children safely.

Concussion protocols established (The Gfeller-Waller Athletic Concussion Awareness Act — H792). This act requires that coaches, other school personnel and parents of middle and high school athletes receive information about concussions and prohibits same-day return-to-play. Only once cleared for play by specified health providers may athletes later return to practice or play.

Changes to the graduated driver licenses system monitored. Since North Carolina adopted graduated driver licensing, crashes are down 38% for 16-year-olds and 20% for 17-year-olds, among the best results of any state. Time spent driving and gaining experience is critical for teens learning to drive more safely. Changes from Modify Graduated Licensing Requirements (S636) include requiring that learning drivers keep a log of time and conditions driven. Additionally, a provisional license will be revoked if the licensee is charged with a variety of serious driving violations, such as excessive speeding. The Division of Motor Vehicles is charged with evaluating the effectiveness of the provisions.

Endorsed. The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant).

2012

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday. Elements of the package include the following: $350,000 for the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; $375,000 to the East Carolina University High-Risk Maternity Clinic and $47,000 for17-Progesterone distribution to help prevent pre-term births. These items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, funding for Safe Sleep and the NC Healthy Start Foundation were eliminated.

Replacement of conventional smoke alarms with tamper-resistant lithium-battery alarms in rental units (S77). Over the past five years, 75 children and hundreds of adults have died due to fire. Fire and flame is the fourth leading cause of death of North Carolina

children ages five to nine. Furthermore, national data reveal that two-thirds of fire deaths occur in homes without an operating smoke alarm, often because the battery has been removed or is not working. The new science of tamper-resistant lithium battery alarms can help solve this problem since alarms with these batteries work for ten years and the batteries cannot be removed for other uses. This measure requires landlords to phase-in tamper-resistant lithium battery units as conventional battery units are scheduled for replacement.

Funding to preserve evidence-based treatment programs for children maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that works together to help screen and treat at-risk children: Funding was maintained at flat levels, often with federal funds, for the Child Medical Evaluation Program, Child Advocacy Centers, the Child Treatment Program and suicide gatekeeper programs.

Endorsed. The Perinatal Quality Collaborative of NC received $250,000 in funding (from the Maternal and Child Health Block Grant). A bill (H176) passed addressing concerns on tracking of domestic violence cases to make clearer when "assault on a female" (or other crimes) occur between intimate partners or strangers. In addition to improving data and understanding of ways to address problems, this may help workers within the Division of Social Services have more complete information on when domestic violence is a factor in the home. Smoking cessation and prevention was funded at $2.7 million from the Social Services Block Grant.

2013

Revise Controlled Substance Reporting (S222). Poisoning is the fastest growing cause of teen death. The bill made changes to the Controlled Substance Reporting System (CSRS) to deter pill mills, to make it easier for doctors to check to see previous prescription-fill history to avoid duplicate prescriptions and to offer treatment as needed, to provide more timely data, and to allow data tracking relating to atypical prescribing or filling, as well as other provisions.

Require Pulse Oximetry Screening (S98). Pulse oximetry is a quick and inexpensive test that screens newborns for certain congenital heart disease. If the baby is sent home before this condition is detected, the baby may get very sick and need to be rushed to the hospital for emergency surgery. Pulse oximetry screening allows timely, non-emergency intervention than can save lives.

Health Curriculum/Preterm Birth (S132). Prematurity is one of the leading causes of infant deaths. This bill incorporates into the Healthy Behaviors Curriculum information about the preventable risks of preterm birth including induced abortion, smoking, alcohol consumption, the use of illicit drugs and inadequate prenatal care.

Funding to preserve infant mortality prevention infrastructure partially maintained. Due to on-going state budget constraints, the CFTF focused on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births, NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies, the Perinatal Quality Collaborative to promote best practices with hospitals, the Safe Sleep Campaign to promote safe sleep including in hospitals, and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to

reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women.

Funding for Child Treatment Program. The Child Treatment Program (CTP) is an evidence-based treatment for children who have experienced trauma. The CFTF supported funding of $2 million for an implementation platform to assure the treatment was used statewide with fidelity. Funding was included in the budget.

Funding for services to stabilize families and prevent children from being removed for their homes. Changes in federal funding resulted in loss of $12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of $4.8 million was provided.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; measures to make it easier for doctors to prescribe and third parties to use a medication (naloxone) to reverse drug overdoses (S20).

2014

Funding to preserve infant mortality prevention infrastructure partially maintained. The CFTF continued to focus on maintaining a package of services that work together to help babies be born healthy and to make it to their first birthdays. Elements of the package include the following: the NC Preconception Health Campaign to decrease neural tube defects and improve birth outcomes; East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births, NC Healthy Start Foundation to provide community-based organization with evidence-based strategies and communications to improve the health of women of reproductive age and their babies, the Perinatal Quality Collaborative to promote best practices with hospitals, the Safe Sleep.

Campaign to promote safe sleep including in hospitals, and You Quit Two Quit to provide training assistance to help medical practices implement evidence-based protocols to reduce smoking by pregnant women. ECU was funded recurring with state funds. Other funded items were funded nonrecurring out of the Maternal and Child Health Block Grant. However, no funding was provided for the Healthy Start Foundation or You Quit Two Quit tobacco cessation for women. A special budget provision allows programs that provide tobacco cessation services for pregnant women and new mothers to apply for a certain competitive grant process.

Funding for services to stabilize families and prevent children from being removed from their homes. Changes in federal funding resulted in loss of $12 million to the Division of Social Services for services to help keep children at-risk of abuse or neglect safe in their own homes. Funding of at least $9 million was provided.

Coverage of lactation support through the Division of Medical Assistance: Given the strong cost savings and lifesaving benefits of breastfeeding, DMA was authorized to reimburse costs associated with lactation consultants. (Initially, legislation was sought but it was later determined to be unnecessary.) This is estimated to save 14 to 18 infant lives per year.

Endorsed. Funding for Child Advocacy Centers and the Child Medical Evaluation Program; authorization of DENR to participate in the Interstate Chemicals Clearinghouse for the purposes of access to key data necessary to enhance safety in use of toxic chemicals.

2015

A new law protecting children from nicotine poisoning: North Carolina became one of the first states to prohibit the sale of e-cigarette liquid containers without child-resistant packaging and without labeling those that contain nicotine. This protects small children who may access liquid nicotine (often sold in candy or fruit flavors) resulting in exposure that may cause injury or death. Calls to Carolinas Poison Centers related to liquid nicotine have risen dramatically in recent years, going from 8 calls in 2011 to 137 calls in 2014.

A new law protecting children from skin cancer: The "Jim Fulghum Teen Skin Cancer Prevention Act" prohibits tanning bed operators from allowing persons under age 18 to use their tanning equipment. With melanoma rates in North Carolina that are higher than the national average and studies showing that the majority of melanoma cases in young adults are connected to indoor tanning bed use, the purpose of this measure is to reduce the incidence of skin cancer.

Measures to address prescription drug misuse and poisoning: Approximately 1 in 5 high school seniors in NC reports having taken prescription drugs without a prescription. Medications are among the most common type of exposure prompting calls to Carolinas Poison Control Center regarding children and adolescents. The CFTF recommended funding for safe drug disposal (Operation Medicine Drop) to decrease access to drugs that can result in misuse or poisoning, and this item was funded as non-recurring. The CFTF endorsed the reinstatement of funding for Carolina's Poison Control Center, which was funded as recurring, and endorsed measures to strengthen the Controlled Substances Reporting System, resulting in a number of improvements to the system.

Endorsed: Funding to preserve infant mortality prevention infrastructure: The CFTF focused on maintaining a package of services that works together to help babies be born healthy and to make it to their first birthday, including funding for the following: East Carolina University High-Risk Maternity Clinic to treat high-risk pregnancies in the eastern part of the state;17-Progesterone distribution to help prevent pre-term births; the Perinatal Quality Collaborative (PQCNC) to promote best practices with hospitals; the Safe Sleep Campaign to promote safe sleep; and the NC March of Dimes Preconception Health Campaign to decrease birth defects and improve birth outcomes. ECU and PQCNC were funded with state funds. Other items were funded out of the Maternal and Child Health Block Grant.

Endorsed: Funding to support accredited Child Advocacy Centers in North Carolina, who provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CACs were funded with nonrecurring state funding and maintained block grant funding.

2016

Funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top 4 causes of infant mortality in NC. The goal of You Quit Two Quit Program, which received $250,000 in nonrecurring funds, is to ensure that there is a comprehensive system in place for high quality screening and treatment for tobacco use in women, including pregnant and postpartum mothers.

Funding for safe drug disposal: Operation Medicine Drop, which received $120,000 in nonrecurring funds, is a nationally recognized NC program that uses drug take-back events and permanent medicine drop boxes to collect 15 to 20 million doses of unused medications each year. Safe disposal of medications is one tool to addresses a current epidemic of prescription drug misuse and drug overdose by reducing access to drugs, particularly by small children and teens who often obtain drugs from friends and family.

A new law prohibiting unlawful transfer of custody of a child: This legislation is aimed at preventing child maltreatment, including situations where a parent or guardian feels unable or unwilling to care for his or her child and locates a stranger, for example over the internet, who takes physical custody of the child. Such unlawful transfers can result in children ending up in abusive or neglectful homes or in human trafficking rings. [Session Law 2016-115]

Change in CSRS law to facilitate research and education: The Controlled Substances Reporting System (CSRS) is an important tool in NC's battle to understand and react to the current opioid overdose epidemic. Prior to this technical change, the law required CSRS data purging at 6 years, preventing epidemiologists and researchers from doing effective longitudinal evaluation and analysis of the CSRS system and trends. This change to the law requires quarterly purging of data more than 6 years old, but instead of permanently discarding the data, it will now be maintained in a separate database so that it can be used for statistical, research, or educational purposes.

Endorsed: Funding to support Children's Advocacy Centers in North Carolina. Children's Advocacy Centers provide services for abused children by bringing together local child protective services, law enforcement, prosecutors, and medical and mental health providers. The CAC model is an evidence-based national model with multiple proven benefits for children.

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2016 budget: Perinatal Quality Collaborative NC; East Carolina University High Risk Maternity Clinic; March of Dimes Preconception Health Campaign; 17-Progesterone; Safe Sleep Campaign.

2017

Recurring funding for perinatal tobacco cessation and prevention: Tobacco use during pregnancy is directly associated with the top 4 causes of infant mortality in NC. The 2017 legislative budget contained $500,000 in recurring funds for both the You Quit Two Quit Program and Quitline NC, both of which can help prevent tobacco use during pregnancy.

Recurring funding to the Child Medical Evaluation Program: A Child Medical Evaluation (CME) is a specific evaluation performed by a qualified medical expert for neglect, physical abuse or sexual abuse when it is suspected that a child is being abused or neglected by their parent. Evaluations are requested, and findings are used by local departments of social services and are also used by medical professionals to determine a course of medical treatment for the child. An increase in recurring funds ($723,000 per year) was needed to bring the reimbursement rate for CMEs in NC to the regional average rate of $575. Prior to this increase, CMEs in NC had been reimbursed a flat fee payment of $250 for suspected sexual abuse and $150 for other types of suspected maltreatment, putting North Carolina at risk of losing these specialized professionals for this important work requiring extensive hours and a high degree of expertise.

CFTF was one of many seeking strengthened tools for combating the opioid epidemic: In 2017, a major piece of legislation called the "STOP Act" (Strengthen Opioid Misuse Prevention Act) containing numerous provisions addressing strategies for preventing opioid misuse passed the legislature unanimously (S.L. 2017-74). Many organizations and individuals were involved in advancing the STOP Act and although the CFTF was not primarily responsible, some of the STOP Act provisions aligned with 2017 CFTF Action Agenda recommendations: the STOP Act includes mandatory use of the Controlled Substances Reporting System by the medical profession (the Task Force recommended

increased use of CSRS by medical profession); the STOP Act made a technical correction in the law to enable interstate data sharing for the Controlled Substances Reporting System (a recommendation by the CFTF); the STOP Act removed some barriers and provided funding for the Harm Reduction Coalition to continue their important work (the CFTF endorsed the efforts of the Harm Reduction Coalition to continue their work fighting the opioid epidemic).

Endorsed: Legislation authorizing civil penalties for passing a stopped school bus and the utilization of school bus cameras to facilitate automatic civil enforcement. [S.L. 2017-188]

Monitored and maintained: Funds provided to the following perinatal health programs previously supported by the Child Fatality Task Force remained unchanged in the 2017 budget: March of Dimes Preconception Health Campaign; 17-Progesterone; Safe Sleep Campaign. The CFTF had been monitoring implementation of the child welfare case management system as part of NC FAST and the 2017 legislative budget contained funding for this purpose.

Child Fatality Prevention System Summit held on April 9th and 10th, 2018 in Raleigh. Although not a legislative event, this was a first-of-its-kind historic event during which Child Fatality Prevention System professionals from across the state came together to learn from state and national experts, share best practices and challenges, and take part in launching state and local initiatives focused on strengthening the System and creating safer and healthier communities for North Carolina's children. The idea for the Summit originated with the Executive Committee of the Task Force, who received support from the full Task Force for advancing plans for the Summit.

2018

Legislation passed to require a study of maternal and neonatal risk-appropriate care at health care facilities across NC. This legislation requires NC DHHS to study the status of NC delivering hospitals related to capabilities for handling various complexity levels of care for mothers and newborns. The study is to identify disparities, service gaps, and other issues, and to make recommendations to ensure quality care in risk-appropriate facilities. This study is aimed at ensuring that newborns and their mothers can access timely, comprehensive medical services from a medical facility that is able to meet their specific medical needs. [Session Law 2018-93]

Legislation passed to add three conditions to the state's newborn screening program: Pompe (Glycogen Storage Disease Type II), MPS-I (Mucopolysaccharidosis Type I), and X-ALD (X-linked Adrenoleukodystrophy). Early detection of these conditions can lead to early treatments that can prevent or improve many of the effects of these conditions, including prevention of early death. This legislation was addressed in the 2018 budget bill, Session Law 2018-5. The March of Dimes was a significant partner in this work.

School safety grant funding that includes CALM (Counseling on Access to Lethal Means) among the programs for which grants may be used. As part of its work on suicide prevention and addressing access to lethal means, the 2018 CFTF Action Agenda included a recommendation to expand the use of the CALM program in North Carolina. This program is designed to train practitioners (medical, mental health) and others to implement strategies to help those who are deemed to be at risk for suicide by enlisting the help of their families and supportive others to reduce their loved ones' access to lethal means, particularly firearms. The 2018 budget bill, Session Law 2018-

5, included $3 million of funds directed to the Department of Public Instruction to be used for nonrecurring school safety grants to community partners to provide training to help students develop healthy responses to trauma and stress. CALM was included among several trainings designated in the budget bill as being suitable for these grants.

Some funding to add school nurses: As part of its suicide prevention work, the CFTF had recommended $5 million in recurring funds to expand the state's School Nurse Funding Initiative to add 100 nurses in high-need schools to get closer to meeting nationally recommended ratios. The 2018 budget bill, Session Law 2018-15, included $10 million in nonrecurring grants for schools to add school mental health support personnel (defined as nurses, counselors, psychologists, and social workers). (The Program Evaluation Division of the General Assembly released a report in May of 2017 stating that it would cost between $45 and $75 million annually to meet national recommendations for the numbers of nurses in schools.)

Funding for a birth certificate initiative of the Perinatal Quality Collaborative of NC: The 2018 budget bill included funding to support a project of the Perinatal Quality Collaborative of NC intended to improve the accuracy of birth certificate data.

Endorsed: Some recurring funding for the Quitline and You Quit Two Quit perinatal tobacco cessation programs. The CFTF had endorsed the efforts of others to advance $3 million in additional funding for QuitlineNC, a statewide tobacco cessation program. The 2018 budget contained $250,000 in additional recurring funds for both QuitlineNC and the You Quit Two Quit Program (a perinatal tobacco cessation program supported on previous Action Agendas by the CFTF).

Endorsed: Some funding to support tobacco prevention for youth. The CFTF had endorsed the efforts of others to advance $7 million in state funding for youth tobacco prevention. The 2018 budget contained an additional $250,000 in nonrecurring funds for youth tobacco prevention programs.

NC CFPT
NORTH CAROLINA
Child Fatality
Prevention Team

North Carolina Office of the Chief Medical Examiner
Deborah L. Radisch, MD, MPH
Chief Medical Examiner and Chair, NC CFPT

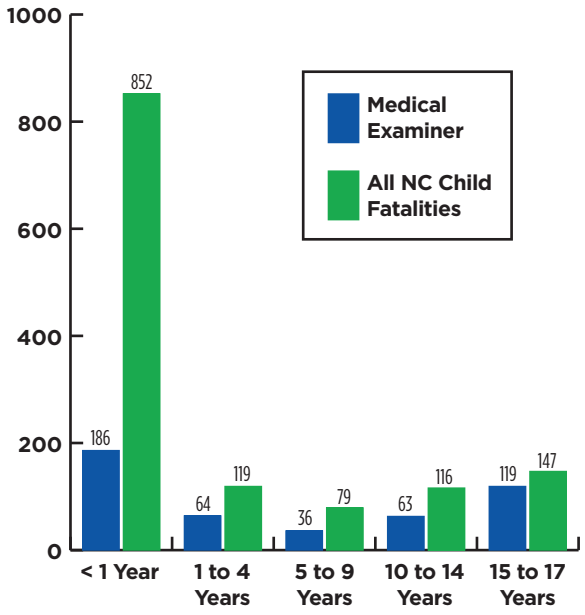
NC Child Fatality Prevention Team Annual Summary
2017 Child Deaths in NC (ages 0-17 years)

Report prepared by:
Kerry Robbins, MS
Research Assistant/Child Fatality Reviewer, NC CFPT
Phone: 919.743.9058 • Fax: 919.743.9099
E-mail: kerry.robbins@dhhs.nc.gov

Report from North Carolina Child Fatality Prevention Team

TOTAL NUMBER OF DEATHS 2017 NORTH CAROLINA RESIDENTS UNDER THE AGE OF 18 YEARS

The State Center for Health Statistics (SCHS) reported that in 2017, 1,313 children died in North Carolina. Many of these deaths were expected and included children who died from a known natural disease or illness. The Office of the Chief Medical Examiner (OCME) investigated the cause and manner of death for 468 of the total North Carolina child fatalities. The cases investigated by the Medical Examiner System included a number of natural deaths, as well as accidental deaths, homicides, suicides, and deaths for which no cause and/or manner of death could be determined.



Note: Total NC Death numbers retrieved from 2017 Child Death Fact Sheet (https://schs.dph.ncdhhs.gov/data/vital/cd/2017/CFinNC2017_v3.pdf)

2017 OCME CHILD FATALITIES BY MANNER AND MEANS		Number
ACCIDENT	Asphyxia	20
	Blunt	1
	Drowning	24
	Exposure	3
	Fall	5
	Fire	3
	Gun	2
	Medical Treatment	1
	Motor vehicle	109
	Toxin	12
HOMICIDE	Asphyxia	5
	Blunt	12
	Drowning	1
	Gun	26
	Sharp	3
	Other	4
	Toxin	1
NATURAL	Natural	54
	SIDS	8
SUICIDE	Asphyxia	24
	Fall/Jump	1
	Gun	18
	Motor vehicle	1
	Toxin	2
UNDETERMINED	Asphyxia	3
	Drowning	1
	Motor vehicle	1
	Toxin	3
	Unknown	113
	Other	7
		TOTAL = 468

The Child Fatality Prevention Team (CFPT) reviews child fatalities that are investigated by the OCME. With a total of 468 deaths investigated by the Medical Examiner System and 1313 North Carolina child deaths, approximately 36% of all child deaths that occurred in North Carolina were reviewed by the CFPT. Additionally, 34 cases are still pending completion and child fatality review and will not be represented below. Due to pending cases, numbers are subject to change. Deaths are categorized as follows:

HOMICIDES

There were 52 children who died at the hands of another in 2017. The CFPT separates homicides into 2 categories; homicides that occur at the hands of a parent or caregiver and homicides that do not.

Homicide by Parent or Caregiver

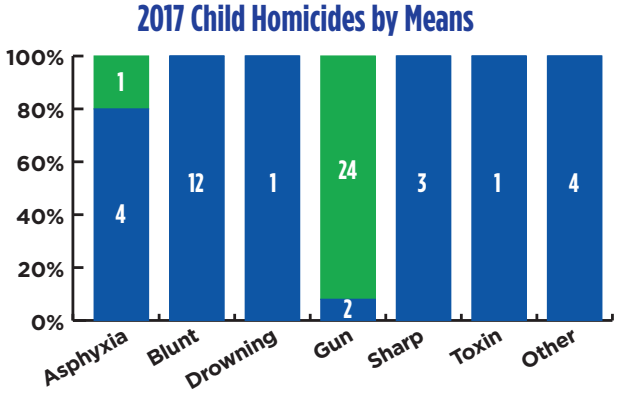
Homicide by Parent or Caretaker deaths accounted for 27 of the 52 total child homicides in 2017. Infants accounted for 13 deaths, and toddlers, ages 1-4 years, accounted for 8 deaths. There were 6 deaths between the ages of 5-17 years: ages 5-9 accounted for 3 deaths, ages 10-14 for 2, and 15-17 for 1 death. Blunt force trauma caused 12 deaths, guns 2, asphyxia 4 and sharp 3 deaths, drowning and tox each for 1 death, and other 4 deaths.

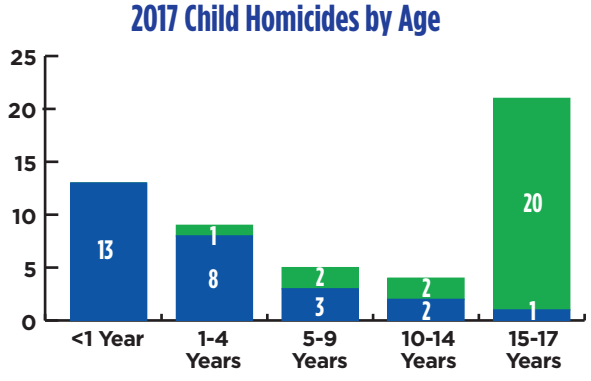
Other Homicides

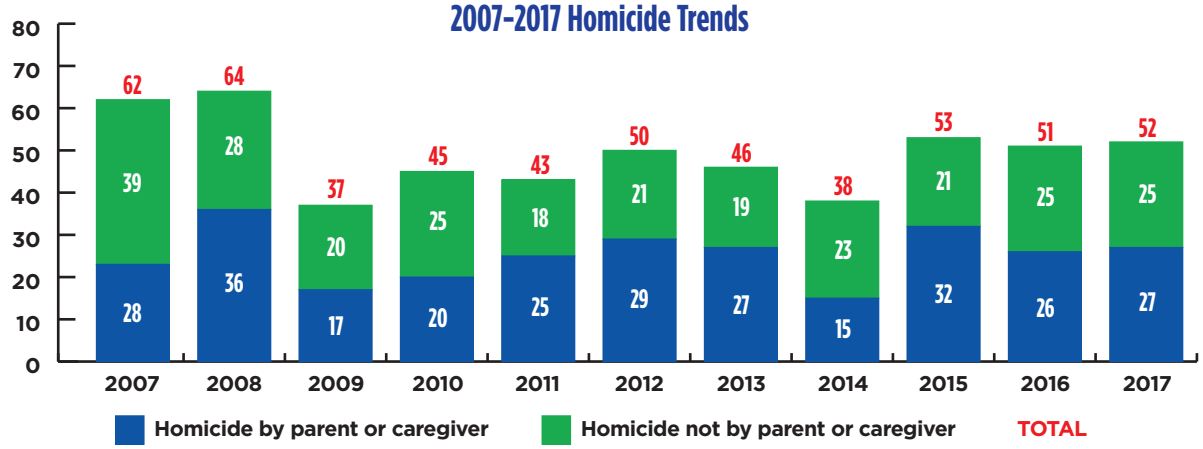
Other homicides, in which the parent or caregiver was not a suspect or perpetrator, comprised 25 of the 52 total 2017 child homicides. Teenagers between the ages of 15 and 17 years accounted for 20 of the homicides. Ages 1 to 4 accounted for 1 death, ages 5 to 9 for 2 and 10 to 14 for 2. Twenty-four of the 25 deaths not by parent or caregiver were due to firearms with 1 due to an asphyxiation.

Of all the homicides, Black non-Hispanic children comprised the majority of homicides, 31 deaths; 20 deaths were White non-Hispanic children, and 1 was unspecified non-Hispanic.

The Child Fatality Prevention Team (CFPT) reviews child fatalities that are investigated by the OCME.



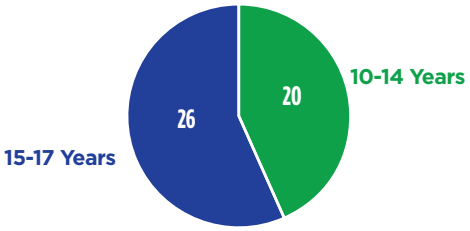




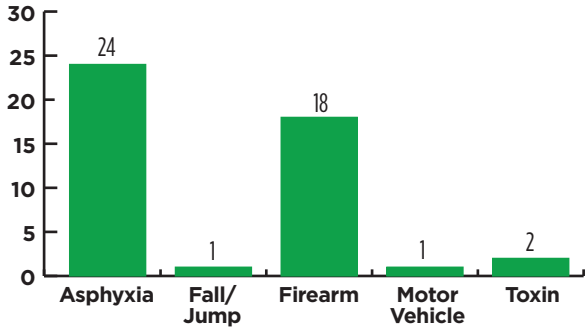
SUICIDES

Suicide was the manner of death of 46 children in 2017. Most children that committed suicide were between the ages of 15 and 17 years, accounting for 26 deaths (55%). There were 20 children between the ages of 10 and 14 years. Males accounted for 35 deaths, females for 11 deaths. The means of death in suicides included asphyxia due to hanging in 24 of the deaths, use of a firearm in 18 of the deaths, 2 from toxic substance, 1 due to motor vehicle crashes, and 1 due to fall/jump.

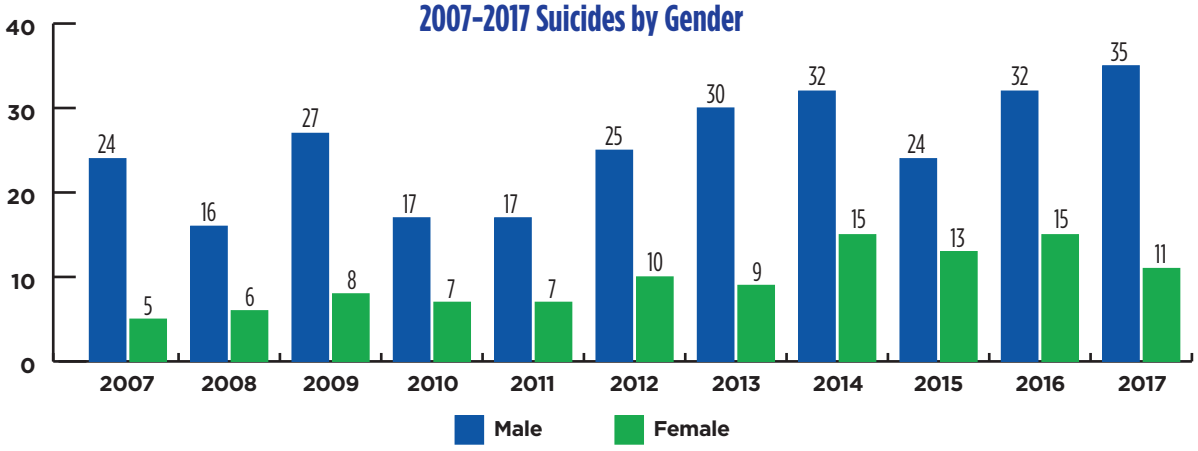
2017 Suicides by Age Category



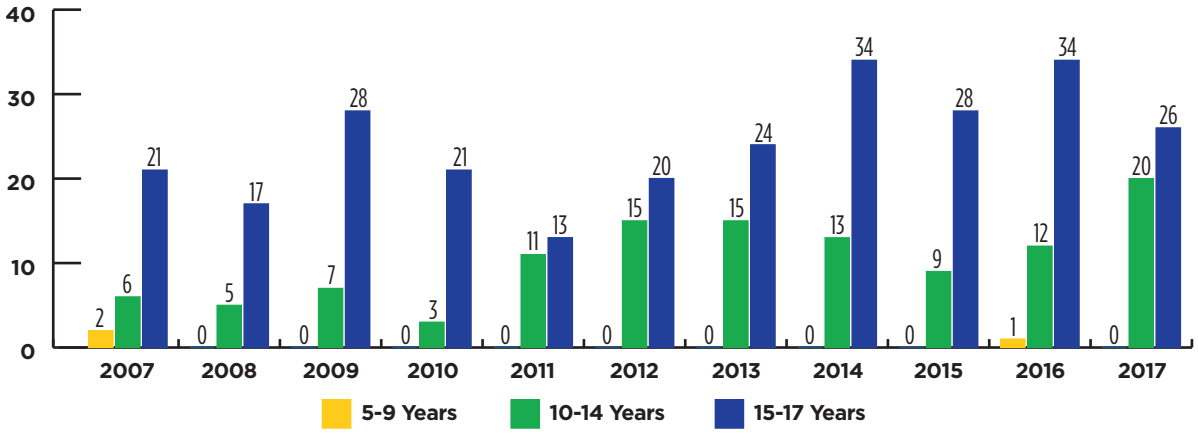
2017 Suicides by Means



2007-2017 Suicides by Gender



2007-2017 Suicides by Age

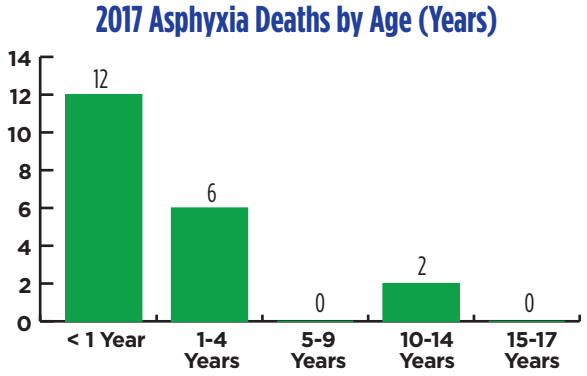


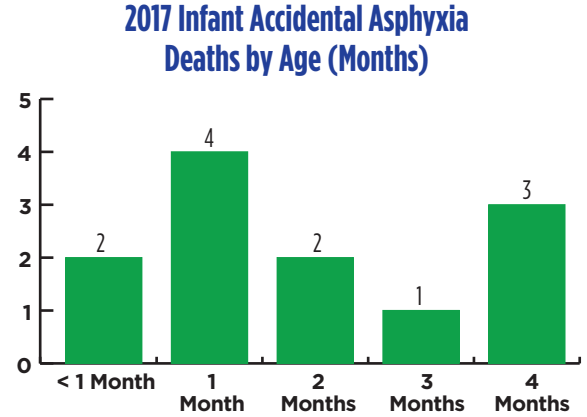
ACCIDENTS

Each year, accidental deaths comprise the largest number of non-natural deaths of children in North Carolina. In 2017, there were 180 deaths investigated by the NC Medical Examiner System certified as manner "accident." The CFPT utilizes multiple means based upon circumstances of these deaths.

Asphyxia

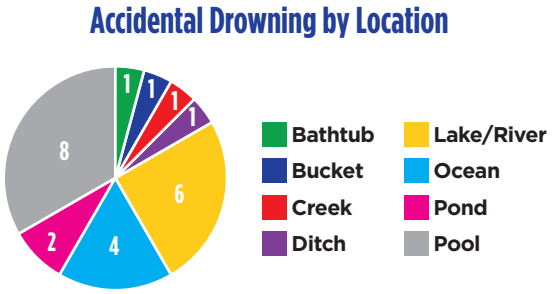
Accidental asphyxiation caused the deaths of 20 children in 2017. Infants constituted the majority, 12, of deaths due to accidental asphyxiation in a sleep environment, either during co-sleeping or by being placed in an unsafe sleep environment (i.e., loose bedding, stuffed animals, misuse of support pillow). Four accidental asphyxia deaths of children between the ages of 1 and 14 years included deaths due to choking on a food bolus, 3 were related to sleep environments, and 1 was due to self-asphyxiation.





Drowning

Drowning resulted in the deaths of 24 children in 2017. Eight drownings occurred in a pool, 6 in a lake or river, 4 in the ocean, 2 in a pond and 1 each in a bathtub, bucket, creek and ditch. Of the drowning deaths, 1 child was under 1 year of age, 10 were ages 1 to 4 years, 2 were ages 5 to 9 years, 2 were ages 10 to 14 years, and 9 were between 15 and 17 years old.



Vehicle-related

In 2017, there were 109 deaths involving vehicles. Most of these deaths, 78, were passengers, while 13 of these deaths were drivers, and 18 were outside of a vehicle/ pedestrian.

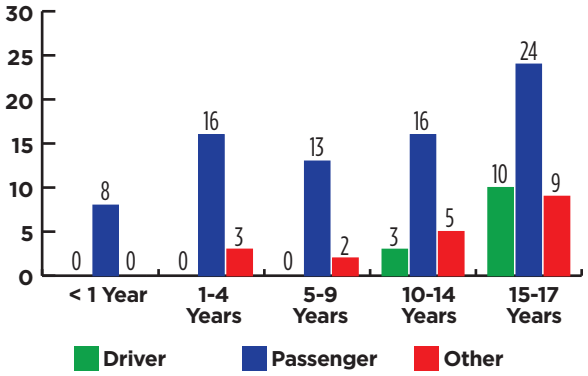
Types of vehicles included 45 passenger cars, 15 SUV's, 11 pickup trucks, and 7 vans. In addition to motor vehicles, other modes of transportation involved in collisions included 5 ATV's, 3 bicycles, 1 motorcycle and 8 unknown vehicles.

Five passengers or pedestrians were hit by drivers under the influence of drugs or alcohol.

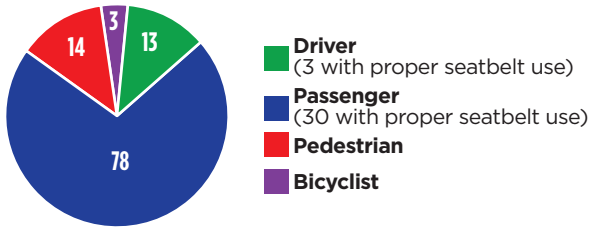
Of the 13 drivers, 3 children were 17-years-old, 6 were 16-years-old, and 4 were 15 years or younger.

Of all the children involved in vehicle-related accidents, 29 children were either not wearing seat belts or were not properly restrained. Of the 13 noted drivers, 3 were wearing proper seat restraints, and among the 78 passengers, 30 had proper seat restraints.

Motor Vehicle Deaths by Age



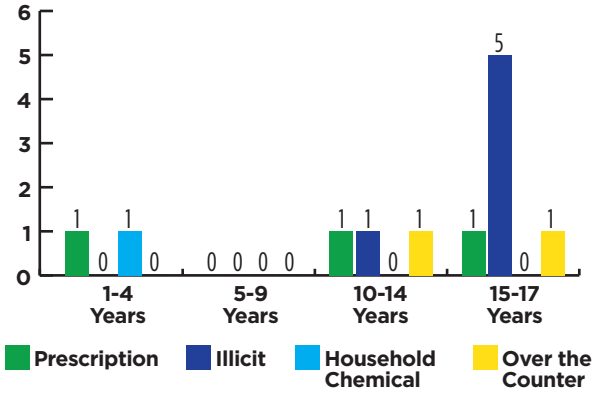
Motor Vehicle Deaths by Position



Toxins

There were 12 deaths from toxic substances (i.e. poisoning). Seven of these children were 15-17 years old, 3 were between ages 10 to 14 years and 2 were between 1 and 4 years old. Seven overdosed on illicit drugs, 2 from prescription drugs, 2 from over the counter medication, and 1 from a household chemical.

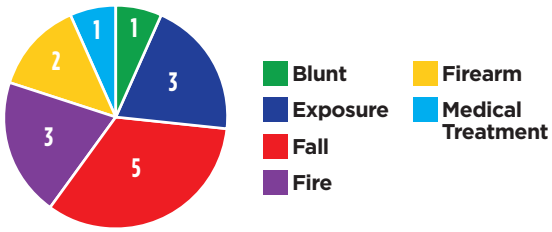
Accidental Toxin Deaths by Age



Other

Other deaths of an accidental manner, totaling 15 deaths, included 1 blunt, 1 medical treatment, 2 firearm, 3 fire, 3 exposure, and 5 fall/jump.

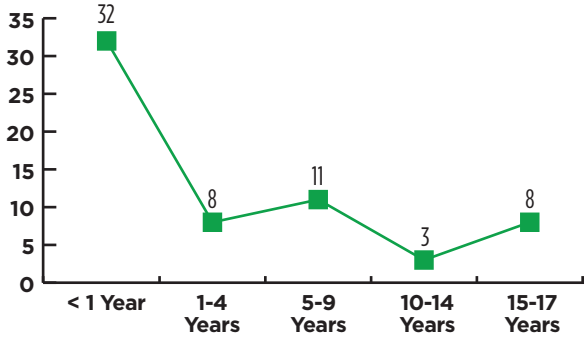
2017 Other Accidental Deaths



NATURAL

Sixty-two deaths were determined to be natural in manner. Of these, 8 were SIDS cases and 54 were other natural causes. The top 5 causes of death with a natural manner in 2017 were: SIDS, pneumonia, myocarditis, seizure, congenital heart defect.

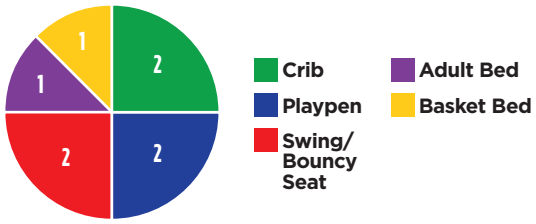
2017 Natural Manner Deaths by Age



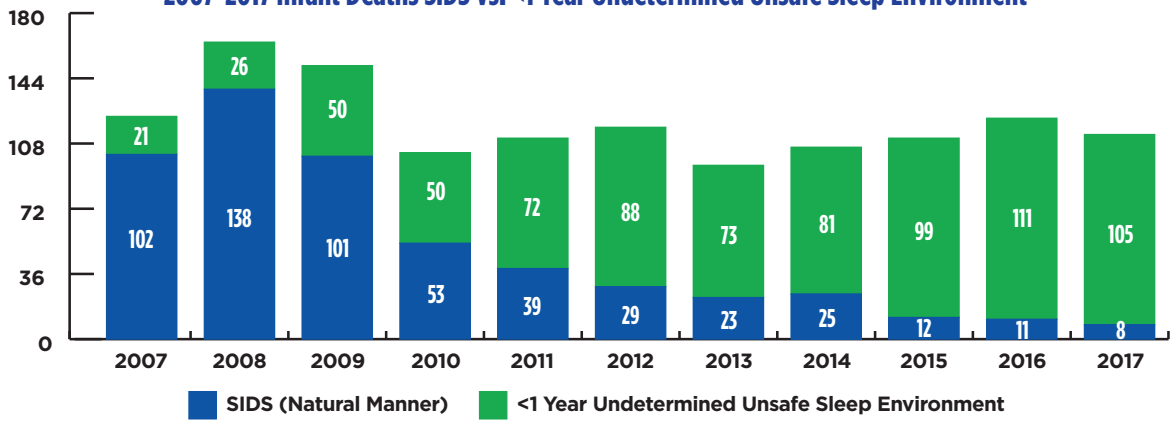
Sudden Infant Death Syndrome

There were 8 infants who died from Sudden Infant Death Syndrome (SIDS) in 2017. The majority of infants, 6, were White, 2 Black. Two deaths occurred in cribs, 2 in a swing/ bouncy seat, 2 in playpens, 1 alone in adult beds, and 1 in a basket bed. Five infants were placed to sleep on their backs, 2 on their sides, and 1 in unspecified positions.

SIDS by Sleep Location



2007-2017 Infant Deaths SIDS vs. <1 Year Undetermined Unsafe Sleep Environment



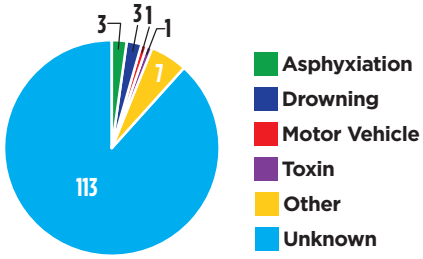
UNDETERMINED

There were 128 deaths that were certified as undetermined manner. Of those, 113 stated unknown means, 3 were an asphyxiation, 3 were related to toxins, 1 to drowning, 1 to motor vehicle and 7 others with other means of death.

Of the undetermined manner, 120 children were under 1 year of age, 4 children were ages 1-4 years, 3 children age 10-14 years, |and 1 child age 15-17 years.

As is the case for most of the infants with an undetermined manner, when a known risky or unsafe sleeping situation is noted, the possibility of asphyxiation as a result of suffocation cannot be entirely excluded which leads to the certification of an unknown means of death.

2017 Undetermined Child Fatalities by Means



RECOMMENDATIONS TO CHILD FATALITY TASK FORCE

In the fall of 2018, the State Child Fatality Prevention Team presented the following recommendations to the Child Fatality Task Force.

Student School Support

- Continue efforts to increase and sustain resources for, without supplanting existing level of effort funding, school mental health professionals at nationally recommended staffing ratios of students to school nurses, school social workers and school psychologists.
- Promote evidence based and informed training in recognizing the risks for suicide and effective strategies for safety planning, reducing access to lethal means, and promoting student resilience for all school personnel.
- Promote effective strategies for students in recognizing anxiety, depression and suicide risk in self, peers, others and ways to get help.

Infant Safe Sleep Practices

The NC Child Fatality Task Force perinatal health committee should study expanding efforts of the UNC Center for Maternal and Infant Health Safe Sleep program to promote best practices for infant safe sleep across the state as well as endorse education and awareness of safe sleep practices and the risks of unsafe sleep environments, including accidental asphyxiation.

Firearm Safety and Access to Lethal Means

Continued support of task force efforts on:

- firearm safety education and awareness of the importance of safe storage;
- suicide prevention training for all school personnel as was outlined in HB-285; and
- safety planning and reducing access to lethal means. Training for school personnel, first responders and school and community health and behavioral health care providers, such as CALM (Counseling on Access to Lethal Means) as an evidenced informed effective strategy routinely used as part of daily practice with children and youth to promote safety planning and reduce access to lethal means.

Child Abuse/Neglect Reporting

The Task Force Intentional Death Committee should study child abuse and neglect reporting with respect to statewide strategies for education on awareness of the NC mandatory reporting law; and the benefit and feasibility of establishing use of a 24/7 statewide 1-800 reporting hotline.

Report from Local Child Fatality Prevention Teams

Local Child Fatality Preventions Teams (CFPTs) are one of two types of local teams in North Carolina who review the deaths of children under age 18 who were born alive and were residents of North Carolina at the time death occurred. The purpose of the reviews is to identify system problems, make recommendations for prevention of future fatalities, and act on those recommendations whenever possible. The majority of CFPT recommendations are focused on local issues. Recommendations and findings from local team reviews are shared with the Team Coordinator via quarterly reports. **Recommendations are also reported to local county commissioners and boards of health as required by NC state statute and the CFPT Agreement Addenda with local health departments. Aggregate data is then provided to the State Team.**

Carolina's 100 counties have one or more local teams who review the county's child fatalities. According to Article 14 of the North Carolina Juvenile Code, Community Child Protection Teams (CCPTs) review all cases in which a child died because of suspected or confirmed abuse or neglect AND a report of abuse or neglect was made to DSS within the previous 12 months OR the child or child's family was a recipient of child protective services within the previous 12 months. All "additional" child fatality cases are reviewed either by the **CCPT** or, if the CCPT does not review "additional" child fatality cases, a **CFPT** reviews them. **Seventy-nine percent are blended CFPT and CCPT.** Each quarter, local CFPTs are provided data on the number of child deaths for each county which include the child's name, date of birth, date and cause of death, among other information. This data is provided through North Carolina's State Center for Health Statistics and the Office of the Chief Medical Examiner.

Local teams are composed of appointed members representing agencies such as the health department, department of social services, police department, district attorney's office, guardian ad litem program, school system, medical examiner's office, fire department, and other child advocacy organizations as well as at-large members.

ON-GOING INITIATIVES AND PROGRAMS

The Children and Youth Branch of the Division of Public Health has sponsored several webinars for CFPT members and updated report forms to provide the most up-to-date information and best practices to local teams on child safety and child fatality prevention:

1. **CFPT Confidential Report Form –** local CFPTs are required to complete a confidential report form for each child death that is reviewed by a team. In our efforts to go paperless with reporting, a planning committee was formed to create and implement a CFPT Electronic Reporting System in Survey Gizmo. This electronic form was part of

a pilot project comprised of members of the local CFPTs who entered test cases to assess the effectiveness of this system. The electronic form is being reviewed to ensure that it is HIPAA compliant before implementation.

2. **Guidelines for Writing Effective System Problems, Recommendations and Actions –** a pre-recorded webinar was created, and the link sent to local CFPT members to provide information and tools on identifying and writing system problems, recommendations for prevention of future child deaths and actions to implement change. This webinar included information on writing clear, concise and measurable reports. The webinar also provided samples of well-written reports to use as a guide.

3. **2018 CFPT Resource Page –** a resource page was created for local team members to access resources and tools needed to conduct child death reviews. With this page local CFPTs can access the current CFPT manual, copies of the new refillable 2-page CFPT Confidential Report Form and Tracking Form, the link to a November 2017 webinar introducing the form, links to other useful websites for data and additional support and, handy tips for completing the report form.

4. **Regional Trainings for local CFPT –** six regional trainings will be held in Spring, 2019 for local CFPT members. Potential topics include recruitment and retention of members, the role of the Health Director in CFPT operations, the role of the Office of Chief Medical Examiner in child death reviews, safe sleep, and mock case reviews. The trainings will be held in Cumberland, Pitt, Haywood, Catawba, Forsyth, and Durham counties. A planning committee was formed in 2018 to begin developing this training.

LOCAL CFPT ACTION

Many local CFPTs collaborate with community groups and state level staff to educate themselves and their communities on a variety of topics including overdose prevention, child safety and safe sleep. Below are highlights of team activities:

Bertie County CFPT: local CFPT in the Albemarle Regional Health Services (ARHS) district collaborated with local departments of social services and local YMCA with distributing the flyer "Drugs and the Body – It Isn't Pretty" to area middle, high school and Science, Technology, Engineering and Mathematics (STEM) students. Contact information to access emergency mental health services through Integrated Services Mobile Crisis, the National Suicide Prevention Hotline, the National Alliance of Mental Illness (NAMI) Helpline, Trillium Health Resources, and anti-bullying resources were provided on the reverse side of the flyer. ARHS printed more than 12,000 flyers and distributed them to schools prior to the 2017-2018 school year. These flyers were also placed in orientation packets and made available at school fairs.

New Hanover County CFPT: the team used CFPT funding to purchase six Pack-N-Plays to distribute to families with infants from birth to 6 months old. Parents were shown how to properly set up the Pack-N-Plays and were given extensive education on safe sleep practices. The team purchased five infant car seats for newborns. These seats were distributed to families of premature and low birth weight infants born in the NICU Neonatal Intensive Care Unit (NICU) of the local hospital. Team members continue to educate themselves on child fatality prevention and child safety issues by attending webinars about Youth Suicide Prevention in NC, Pediatric Traumatic Brain Injury and an Opiate Use seminar sponsored by Coastal Horizons.

Surry County CFPT: using part of the funding allocated to local CFPT, the Pregnancy Care Management Program of Surry County promoted a new initiative that focused on infant safety and prevention of SIDS. Each recipient was given a SleepSack, approved by the American Academy of Pediatrics, along with education promoting infant safe sleep habits for new mothers. The goal was to decrease the use of heavy bedding and pillows in cribs. Prior to delivery, Pregnancy Care Managers reviewed a Baby Safe Sleep Checklist with 25 recipients in 2017 and 55 recipients in 2018. Each recipient signed the checklist upon completion. The cost of the SleepSacks was shared between the Surry County CFPT who purchased 33 SleepSacks and the Health Foundation of the Surry County Health and Nutrition Center who purchased 55.

Chatham County CFPT: local team members participated in two webinars sponsored by the Children and Youth Branch of the Division of Public Health. The first webinar entitled "Addressing the Impact of Prescription Drug Abuse on Children" with guest speaker Ms. Kella Hatcher, Executive Director of the Child Fatality Task Force, focused on current data related to prescription drug abuse, substance use impacts on children and policies addressing the problems. The second webinar, "Youth Suicide Prevention NC: Data, Support and Recommendations", provided information on youth demographics, data on suicide attempts, support services, the circumstances around a suicidal event and, the types of weapons used. This webinar was presented by Ms. Jane Miller, Program Consultant with the Injury and Violence Prevention Unit.

Thank you to all the local child fatality prevention teams (CFPT) for their hard work, dedication and long-term commitment to North Carolina's children.

Child Fatality Task Force Contact Information and Leadership Structure

LEADERSHIP

Executive Director

Kella W. Hatcher
Phone: 919-707-5626
Email: kella.hatcher@dhhs.nc.gov

Chair

Karen McLeod
President/CEO, Benchmarks NC
Phone: 919-828-1864
Email: kmcleod@benchmarksnc.org

COMMITTEES

The Intentional Death Prevention Committee focuses on preventing homicide, suicide, child abuse and neglect.

Co-Chairs

Michelle Hughes, Executive Director, NC Child

Jennifer Kristiansen, Director of Social Services, Chatham County

The Perinatal Health Committee focuses on the reduction of infant mortality with emphasis on perinatal conditions, birth defects, and SIDS.

Co-Chairs

Belinda Pettiford, Branch Head, Women's Health Branch, NC Division of Public Health, NCDHHS

Dr. Sarah Verbiest, Executive Director, UNC-CH Center for Maternal and Infant Health; Director, Jordan Institute for Families

The Unintentional Death Prevention Committee focuses on preventing unintentional child deaths, such as those due to motor vehicles, poisoning, and fire.

Co-Chairs

Alan Dellapenna, Branch Head, Injury and Violence Prevention Branch, NC Division of Public Health, NCDHHS

Martha Sue Hall, Mayor Pro Tempore, City of Albemarle

NC Child Fatality Task Force Members*

Senator Chad Barefoot
NC Senate

Michael Becketts
Assistant Secretary for Human Services, NCDHHS

Stan Bingham
Public Member

Cindy Bizzell
Administrator, Guardian Ad Litem Program, Administrative Office of the Courts

Brent Culbertson
Assistant Director, State Bureau of Investigation

Senator Don Davis
NC Senate

Senator Cathy Dunn
NC Senate

Dr. Ellen Essick
NC Healthy Schools, NC Department of Public Instruction

Martha Sue Hall
Mayor Pro Tempore, Albemarle City Council

Senator Kathy Harrington
NC Senate

John P. Harris
Brevard Chief of Police

Representative Craig Horn
NC House of Representatives

Michelle Hughes
Executive Director, NC Child

Steve Jarvis
County Commissioner, Davidson County

Dr. Kelly Kimple
Section Chief, Women's & Children's Health, NC Division of Public Health, NCDHHS

Sarah Kirkman
Conference of District Attorneys

Senator Joyce Krawiec
NC Senate

Jennifer Kristiansen
Director of Social Services, Chatham County

Representative Donny Lambeth
NC House of Representatives

Dana Mangum
Executive Director, NC Coalition Against Domestic Violence

Dr. Ben Matthews
Chief School Operations Officer, NC Department of Public Instruction

Dr. Martin McCaffrey
Perinatal Quality Collaborative of NC

Karen McLeod
CEO, Benchmarks

Representative Gregory Murphy
NC House of Representatives

Katherine Pope
Public Member

Dr. Deborah Radisch
NC Chief Medical Examiner

Representative Robert Reives, II
NC House of Representatives

Susan E. Robinson
Prevention and Early Intervention, DMH/DD/SAS, NCDHHS

Stacie Saunders
Health Director, Alamance County

Bradford Sneeden
Legislative Counsel, NC Department of Justice

Pamela T. Thompson
Alamance-Burlington School Board, NC Domestic Violence Commission

Dr. Betsey Tilson
State Health Director & Chief Medical Officer, NC DHHS

Dr. Sarah Verbiest
Executive Director, UNC Center for Maternal and Infant Health; Director, Jordan Institute for Families

Representative Donna White
NC House of Representatives

Mary Williams-Stover
Director, Council for Women & Youth Involvement

This list reflects membership as of December 2018